

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

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

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

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

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

So I just wanted to rise to congratulate the Senator's vision on putting forward the right plan that makes sure that, in fact, our seniors know they can count on a \$35 premium. They would also not have to have a deductible. Seventy percent, as I understand, of their prescription drug costs would be paid for. There would be no gap in coverage

for the last few months of the year. Or if you found yourself getting to a point where you reached the end of your coverage, and then, unfortunately, your doctor indicates you have an even more serious illness to deal with, you would not be left wondering what to do to pay for that treatment and medication.

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

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

TAX RELIEF, SIMPLIFICATION, AND EQUITY ACT OF 2003

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

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

Mr. SMITH. I believe that is true.

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

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

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

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

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

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

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

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

Mr. REID. Mr. President, the Senator from New Hampshire has been more than generous with his patience. I

would ask, however, unanimous consent that the time until 11 o'clock be for debate only on this matter. I have spoken to the majority, and they are in agreement with that. So I ask the time until 11 o'clock be for debate only on the bill.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

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

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

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

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

PRESCRIPTION DRUG AND MEDICAL CARE IMPROVEMENT ACT OF 2003—Resumed

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

The assistant legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

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

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

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

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

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

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

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

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

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

For example, in 1950 there were 12.5 people working for every 1 person retired. This year, there is something like 3.3, 3.5 people working for every 1 person retired. By the time we hit 2030, there are going to be 2 people working for every 1 person retired. The number of people retired today is 40 million. The number of people who will be retired in the year 2030 will be 70 million, a 75 percent increase. So the system, which was structured to be a pyramid and has worked very well as a pyramid, simply won't work effectively as a rec-

tangle. You can't have about as many people working, paying retirement benefits, as you have people taking those benefits because the practical effect of that is you would have to dramatically increase the taxes on working Americans in order to support nonworking retired Americans to a point where working Americans' lifestyles would be significantly reduced.

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

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

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

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

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

We have to find some way to address the Medicare system in a manner which will allow us to make it affordable as we move into the outyears. This means putting some cost sensitivity into its structure. If we are going to add a new benefit to Medicare,

we have to be sensitive that it does not at the same time create a massive new unfunded liability.

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

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

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

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

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

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

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

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

It has been estimated that 75 percent of the seniors in the country today already have some form of drug coverage. Why should the Federal Government come in and replace that? Why should the Federal Government come in and say to General Motors, which negotiated a contract with its employees that when they retire they would get a health care package that gave them drug coverage—why should you, a person working at a restaurant in Claremont, NH, in your twenties, trying to raise two kids and send them to school—why should your Medicare and health insurance tax be taken to pay for a drug benefit for somebody who retired from General Motors, who already has a benefit under the terms of the agreement they negotiated with General Motors? All you are essentially doing is saying, if you do that, that some poor guy or woman who is working hard to make ends meet in Claremont, NH, in a restaurant is going to bear the burden of what General Motors should be bearing for its retirees. You are replacing the obligation of General Motors with the obliga-

tion of some poor guy or woman in their twenties or thirties who is trying to raise a family and is working in a restaurant, and they have two kids going to school. They have to buy a Chevrolet, which is a pretty expensive experience. They should not have to pay for the health care of the person who made that Chevrolet. But that is what this bill essentially does.

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

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

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

The second flaw in this bill, the most fundamental flaw, is the issue of how you control the overall cost of Medicare. This is at the essence of the future financial soundness of this country. Today, Medicare consumes about 14 percent of the GDP, if you include retirement benefits, Social Security, Medicare, and Medicaid. If you applied the projections to the Medicare, which are in place, the fact that we have a \$13 trillion unfunded liability, and if you apply the unfunded liability projec-

tions to Social Security and Medicaid, then you will end up by 2030 having those three—Social Security, Medicare and Medicaid—absorbing 14 percent of the GDP. They do not do that today, obviously. Today, the Federal Government absorbs about 19 percent of the gross domestic product. So you could see that if you project the cost of Medicare and Social Security out to 2030 and you have it using up 14 percent of the gross national product, and today we do all Government spending, all the Government responsibilities, including education, national defense, and all the different issues of core Government needs we manage with 19 percent of the gross national product, we can see that by the time we get to the year 2030, there is not going to be anything left that the Federal Government is going to be able to do other than take care of the retirement accounts. We are not going to be able to do national defense, education, roads, parks—all the important functions to have a strong Government and a good society. They are not going to be affordable unless we are willing to radically increase the taxes on the working Americans of this country who will be our children and our grandchildren.

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

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

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

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

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

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

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

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

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

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

The great tragedy is this drug benefit gave us, the Congress and the executive branch, the first and best opportunity to substantively reform Medicare using the drug benefit basically as the carrot that brings along the reforms. We could have used this benefit in an extraordinarily constructive way to assure that my generation, the baby

boom generation, is not an undue burden on our children and our grandchildren or on that fellow or woman working in a restaurant in Claremont.

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

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

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

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

The PRESIDING OFFICER. That is correct.

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

Mr. KENNEDY. We now will be recognized?

Mr. REID. For debate only on the bill.

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

Mr. REID. I will be happy to.

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

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

Mr. KENNEDY. We have 9 minutes?

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

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

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

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

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

Mr. REID. Mr. President, I do not know if the two managers of the bill

would be willing to start at 11:15 rather than 11. They are in the cloakroom. While Senator KENNEDY speaks, I will walk back and ask them.

Mr. CRAIG. That would be appreciated.

The PRESIDING OFFICER. The Senator from Massachusetts.

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

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

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

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

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

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

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

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

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

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

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

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

We have seen an alteration and change, and that is what has been developed in the Senate Finance Com-

mittee legislation, which will permit those who are under Medicare to be assured that no matter what part of the country they live in they are going to be able to have access to the prescription drug program that is outlined in this legislation.

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

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

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

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

This is against another background that I will just mention very briefly. We have seen in the Congress, in the Senate, over the period of this last 5 years the doubling of the NIH budget. Why was that done? The reason it was done is the recognition that we have had, Republicans and Democrats alike,

of the enormous opportunities for breakthroughs, in prescription drugs primarily, and in new technologies to deal with the challenges in health care, mixing technologies and mixing prescription drugs to make further advances—which is certainly the goal of Dr. Sahni at the NIH.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Finally, let me say in watching what happened over in the House of Representatives, their legislation fails to have the kind of backup this legisla-

tion has in the delivery of the Medicare benefit, which is unacceptable. They have what they call a premium support program which effectively would undermine the Medicare system, which is completely unacceptable. The means testing is in there, which would require individuals to submit their tax forms to agencies of the Federal Government and insurance companies. I think that would be very offensive.

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

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

I see the hour of 11 has arrived.

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

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

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

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

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

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

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

importantly, a lot of the things Senator BAUCUS and I had to work out.

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

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

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

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

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

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

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

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

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

The PRESIDING OFFICER. The Senator from Idaho.

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

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

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

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

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

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

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

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

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

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

I am especially pleased that this legislation devotes the greatest share of its drug assistance to seniors of low and modest income—most especially seniors below 160 percent of poverty. These seniors—those with annual incomes below about \$13,500 for an indi-

vidual, and about \$18,200 for a couple—would receive special assistance of about 80 to 90 percent for their drug costs, depending on income.

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

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

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

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

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

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

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

For certain chronic conditions, such as diabetes and congestive heart failure, as many as 83 to 97 percent of America's health care plans now offer such care coordination. Medicare, meanwhile, has only barely begun to experiment with demonstration

projects in this area and some prominent experts, such as former CBO Director Dan Crippen, doubt that care management can ever work effectively in Medicare as we know it today.

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

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

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

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

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

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

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

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

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

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

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

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

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

These concerns are by no means exhaustive. Like many of my colleagues, I am also concerned about the complexity and stability of the proposed system for providing drug coverage in the traditional Medicare program, and I worry about the possibility that some

employers may react to the new Federal drug coverage by cutting back or dropping benefits they currently provide to their retirees.

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

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

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

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

I yield the floor.

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

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

MODIFICATION TO COMMITTEE AMENDMENT

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

The PRESIDING OFFICER. The amendment is so modified.

The committee amendment, as modified, is as follows:

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

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

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

(c) BIPA; SECRETARY.—In this Act:

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

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

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

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

Sec. 101. Medicare voluntary prescription drug delivery program.

“PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

“Sec. 1860D. Definitions; treatment of references to provisions in Medicare Advantage program.

“Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

“Sec. 1860D-1. Establishment of voluntary prescription drug delivery program.

“Sec. 1860D-2. Enrollment under program.

“Sec. 1860D-3. Election of a Medicare Prescription Drug plan.

“Sec. 1860D-4. Providing information to beneficiaries.

“Sec. 1860D-5. Beneficiary protections.

“Sec. 1860D-6. Prescription drug benefits.

“Sec. 1860D-7. Requirements for entities offering Medicare Prescription Drug plans; establishment of standards.

“Subpart 2—Prescription Drug Delivery System

“Sec. 1860D-10. Establishment of service areas.

“Sec. 1860D-11. Publication of risk adjusters.

“Sec. 1860D-12. Submission of bids for proposed Medicare Prescription Drug plans.

“Sec. 1860D-13. Approval of proposed Medicare Prescription Drug plans.

“Sec. 1860D-14. Computation of monthly standard prescription drug coverage premiums.

“Sec. 1860D-15. Computation of monthly national average premium.

“Sec. 1860D-16. Payments to eligible entities.

“Sec. 1860D-17. Computation of monthly beneficiary obligation.

“Sec. 1860D-18. Collection of monthly beneficiary obligation.

“Sec. 1860D-19. Premium and cost-sharing subsidies for low-income individuals.

“Sec. 1860D-20. Reinsurance payments for expenses incurred in providing prescription drug coverage above the annual out-of-pocket threshold.

“Sec. 1860D-21. Direct subsidy for sponsor of a qualified retiree prescription drug plan for plan enrollees eligible for, but not enrolled in, this part.

“Subpart 3—Miscellaneous Provisions

“Sec. 1860D-25. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

- “Sec. 1860D–26. Other related provisions.
- Sec. 102. Study and report on permitting part B only individuals to enroll in medicare voluntary prescription drug delivery program.
- Sec. 103. Rules relating to medigap policies that provide prescription drug coverage.
- Sec. 104. Medicaid and other amendments related to low-income beneficiaries.
- Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).
- Sec. 106. Study regarding variations in spending and drug utilization.
- Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries
- Sec. 111. Medicare prescription drug discount card and transitional assistance for low-income beneficiaries.
- Subtitle C—Standards for Electronic Prescribing
- Sec. 121. Standards for electronic prescribing.
- Subtitle D—Other Provisions
- Sec. 131. Additional requirements for annual financial report and oversight on medicare program.
- Sec. 132. Trustees’ report on medicare’s unfunded obligations.
- TITLE II—MEDICAREADVANTAGE
- Subtitle A—MedicareAdvantage Competition
- Sec. 201. Eligibility, election, and enrollment.
- Sec. 202. Benefits and beneficiary protections.
- Sec. 203. Payments to MedicareAdvantage organizations.
- Sec. 204. Submission of bids; premiums.
- Sec. 205. Special rules for prescription drug benefits.
- Sec. 206. Facilitating employer participation.
- Sec. 207. Administration by the Center for Medicare Choices.
- Sec. 208. Conforming amendments.
- Sec. 209. Effective date.
- Subtitle B—Preferred Provider Organizations
- Sec. 211. Establishment of MedicareAdvantage preferred provider program option.
- Subtitle C—Other Managed Care Reforms
- Sec. 221. Extension of reasonable cost contracts.
- Sec. 222. Specialized Medicare+Choice plans for special needs beneficiaries.
- Sec. 223. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
- Sec. 224. Institute of Medicine evaluation and report on health care performance measures.
- Sec. 225. Expanding the work of medicare quality improvement organizations to include parts C and D.
- TITLE III—CENTER FOR MEDICARE CHOICES
- Sec. 301. Establishment of the Center for Medicare Choices.
- Sec. 302. Miscellaneous administrative provisions.
- TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS
- Subtitle A—Provisions Relating to Part A
- Sec. 401. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.
- Sec. 402. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.
- Sec. 403. Medicare inpatient hospital payment adjustment for low-volume hospitals.
- Sec. 404. Fairness in the medicare disproportionate share hospital (DSH) adjustment for rural hospitals.
- Sec. 405. Critical access hospital (CAH) improvements.
- Sec. 406. Authorizing use of arrangements to provide core hospice services in certain circumstances.
- Sec. 407. Services provided to hospice patients by nurse practitioners, clinical nurse specialists, and physician assistants.
- Sec. 408. Authority to include costs of training of psychologists in payments to hospitals under medicare.
- Sec. 409. Revision of Federal rate for hospitals in Puerto Rico.
- Sec. 410. Authority regarding geriatric fellowships.
- Sec. 411. Clarification of congressional intent regarding the counting of residents in a nonprovider setting and a technical amendment regarding the 3-year rolling average and the IME ratio.
- Sec. 412. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
- Sec. 413. GAO study and report on appropriateness of payments under the prospective payment system for inpatient hospital services.
- Subtitle B—Provisions Relating to Part B
- Sec. 421. Establishment of floor on geographic adjustments of payments for physicians’ services.
- Sec. 422. Medicare incentive payment program improvements.
- Sec. 423. Increase in renal dialysis composite rate.
- Sec. 424. Extension of hold harmless provisions for small rural hospitals and treatment of certain sole community hospitals to limit decline in payment under the OPD PPS.
- Sec. 425. Increase in payments for certain services furnished by small rural and sole community hospitals under medicare prospective payment system for hospital outpatient department services.
- Sec. 426. Increase for ground ambulance services furnished in a rural area.
- Sec. 427. Ensuring appropriate coverage of air ambulance services under ambulance fee schedule.
- Sec. 428. Treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital.
- Sec. 429. Improvement in rural health clinic reimbursement.
- Sec. 430. Elimination of consolidated billing for certain services under the medicare PPS for skilled nursing facility services.
- Sec. 431. Freeze in payments for certain items of durable medical equipment and certain orthotics; establishment of quality standards and accreditation requirements for DME providers.
- Sec. 432. Application of coinsurance and deductible for clinical diagnostic laboratory tests.
- Sec. 433. Basing medicare payments for covered outpatient drugs on market prices.
- Sec. 434. Indexing part B deductible to inflation.
- Sec. 435. Revisions to reassignment provisions.
- Sec. 436. Extension of treatment of certain physician pathology services under medicare.
- Sec. 437. Adequate reimbursement for outpatient pharmacy therapy under the hospital outpatient PPS.
- Sec. 438. Limitation of application of functional equivalence standard.
- Sec. 439. Medicare coverage of routine costs associated with certain clinical trials.
- Sec. 440. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 441. Demonstration of coverage of chiropractic services under medicare.
- Sec. 442. Medicare health care quality demonstration programs.
- Sec. 443. Medicare complex clinical care management payment demonstration.
- Sec. 444. Medicare fee-for-service care coordination demonstration program.
- Sec. 445. GAO study of geographic differences in payments for physicians’ services.
- Subtitle C—Provisions Relating to Parts A and B
- Sec. 451. Increase for home health services furnished in a rural area.
- Sec. 452. Limitation on reduction in area wage adjustment factors under the prospective payment system for home health services.
- Sec. 453. Clarifications to certain exceptions to medicare limits on physician referrals.
- Sec. 454. Demonstration program for substitute adult day services.
- TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS
- Subtitle A—Regulatory Reform
- Sec. 501. Rules for the publication of a final regulation based on the previous publication of an interim final regulation.
- Sec. 502. Compliance with changes in regulations and policies.
- Sec. 503. Report on legal and regulatory inconsistencies.
- Subtitle B—Appeals Process Reform
- Sec. 511. Submission of plan for transfer of responsibility for medicare appeals.
- Sec. 512. Expedited access to judicial review.
- Sec. 513. Expedited review of certain provider agreement determinations.
- Sec. 514. Revisions to medicare appeals process.
- Sec. 515. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement; consultation before changing provider enrollment forms.
- Sec. 516. Appeals by providers when there is no other party available.
- Sec. 517. Provider access to review of local coverage determinations.
- Subtitle C—Contracting Reform
- Sec. 521. Increased flexibility in medicare administration.

Subtitle D—Education and Outreach Improvements

- Sec. 531. Provider education and technical assistance.
- Sec. 532. Access to and prompt responses from medicare contractors.
- Sec. 533. Reliance on guidance.
- Sec. 534. Medicare provider ombudsman.
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Subtitle E—Review, Recovery, and Enforcement Reform

- Sec. 541. Prepayment review.
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TITLE VI—OTHER PROVISIONS

- Sec. 601. Increase in medicaid DSH allotments for fiscal years 2004 and 2005.
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- Sec. 605. Assistance with coverage of legal immigrants under the medicaid program and SCHIP.
- Sec. 606. Establishment of consumer ombudsman account.
- Sec. 607. GAO study regarding impact of assets test for low-income beneficiaries.
- Sec. 608. Health care infrastructure improvement.
- Sec. 609. Capital infrastructure revolving loan program.
- Sec. 610. Federal reimbursement of emergency health services furnished to undocumented aliens.
- Sec. 611. Increase in appropriation to the health care fraud and abuse control account.
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- Sec. 614. Extension of customs user fees.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

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

“PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

“DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICAREADVANTAGE PROGRAM

“SEC. 1860D. (a) DEFINITIONS.—In this part: “(1) ADMINISTRATOR.—The term ‘Administrator’ means the Administrator of the Center for Medicare Choices as established under section 1808.

“(2) COVERED DRUG.—

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

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

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

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

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

“(B) EXCLUSIONS.—

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

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

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

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

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

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

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

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

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

“(A) a pharmaceutical benefit management company;

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

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

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

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

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

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

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

“(A) that has been approved under section 1860D-13; and

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

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

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

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

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

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

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

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

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

“Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program
“ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

“SEC. 1860D-1. (a) PROVISION OF BENEFIT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“ENROLLMENT UNDER PROGRAM

“SEC. 1860D-2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

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

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

“(b) SPECIAL ENROLLMENT PROCEDURES.—

“(1) LATE ENROLLMENT PENALTY.—

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

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

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

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

“(C) PERIODS NOT TAKEN INTO ACCOUNT.—

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

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

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

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

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

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

“(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

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

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

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

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

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

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

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

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

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

“(H) DISCLOSURE.—

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

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

“(2) INITIAL ELECTION PERIODS.—

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

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

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

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

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

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

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

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

“(c) PERIOD OF COVERAGE.—

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

“(2) OPEN AND SPECIAL ENROLLMENT.—

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

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

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

“(d) TERMINATION.—

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

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

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

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

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

“ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

“SEC. 1860D-3. (a) IN GENERAL.—

“(1) PROCESS.—

“(A) ELECTION.—

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

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

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

“(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause

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

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

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

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

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

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

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

“(b) ENROLLMENT IN A MEDICARE ADVANTAGE PLAN.—

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

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

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

“PROVIDING INFORMATION TO BENEFICIARIES

“SEC. 1860D-4. (a) ACTIVITIES.—

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

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

“(b) REQUIREMENTS.—

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

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

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

“(i) the Administrator under such section; and

“(ii) the Secretary under section 1804; and

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

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

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

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

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

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

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

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

“BENEFICIARY PROTECTIONS

“SEC. 1860D-5. (a) DISSEMINATION OF INFORMATION.—

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

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

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

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

“(D) Grievance and appeals processes.

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

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

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

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

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

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

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

“(b) ACCESS TO COVERED DRUGS.—

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

“(2) ASSURING PHARMACY ACCESS.—

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

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

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

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

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

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

“(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

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

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

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

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

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

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

“(D) CONSIDERATIONS IN PHARMACY FEES.—The eligible entity offering a Medicare Prescription Drug plan shall take into account, in establishing fees for pharmacists and oth-

ers providing services under the medication therapy management program, the resources and time used in implementing the program.

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

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

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

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

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

“(e) APPEALS.—

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

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

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

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

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

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

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

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

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

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

“PRESCRIPTION DRUG BENEFITS

“SEC. 1860D-6. (a) REQUIREMENTS.—

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

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

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

“(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

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

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

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

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

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

“(1) DEDUCTIBLE.—

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

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

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

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

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

“(3) INITIAL COVERAGE LIMIT.—

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

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

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

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

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

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

“(B) ANNUAL OUT-OF-POCKET LIMIT.—

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

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

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

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

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

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

“(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D-19, under title XIX, or under a State pharmaceutical assistance program and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement for such costs.

“(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of

the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D-2(d).

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

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

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

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

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

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

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

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

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

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

“(e) ACCESS TO NEGOTIATED PRICES.—

“(1) ACCESS.—

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

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

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

“(2) CARDS OR OTHER TECHNOLOGY.—

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

“(B) NATIONAL STANDARDS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(2) ASSUMPTION OF FINANCIAL RISK.—

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

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

“(3) SOLVENCY FOR UNLICENSED ENTITIES.—

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

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

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

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

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

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

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

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

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

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

“(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency

and capital adequacy standards for entities described in paragraph (2).

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

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

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

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

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

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

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

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

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

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

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

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

“(h) RELATION TO STATE LAWS.—

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

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

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

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

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

“(B) Premiums.

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

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

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

benefits regarding a Medicare Prescription Drug plan.

“(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to—
“(A) monthly beneficiary obligations paid to the Administrator for Medicare Prescription Drug plans under this part; or
“(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

“Subpart 2—Prescription Drug Delivery System

“ESTABLISHMENT OF SERVICE AREAS

“SEC. 1860D-10. (a) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

“PUBLICATION OF RISK ADJUSTERS

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

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

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

“(b) ESTABLISHMENT OF RISK ADJUSTERS.—

“(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to plans referred to in subsection

(a) to take into account variation in costs based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments described in paragraphs (1) and (2) of subsection (a).

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

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

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

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

“SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

“SEC. 1860D-12. (a) SUBMISSION.—

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

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

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

“(1) The benefits under the plan (as required under section 1860D-6).

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

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

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

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

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

“(4) The service area for the plan.

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

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

“(c) OPTIONS REGARDING SERVICE AREAS.—

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

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

“(B) the entire area covered by the Medicare program.

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

“APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

“SEC. 1860D-13. (a) APPROVAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

“(1) include the required benefits under section 1860D-6(a)(1); and

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

“(d) ACCESS TO COMPETITIVE COVERAGE.—

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

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

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

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

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

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

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

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

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

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

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

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

“(e) GUARANTEED ACCESS.—

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

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

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

“(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK QUALIFIED BIDS BEFORE ENTERING INTO CONTRACT.—The Administrator may not

enter into a contract under subparagraph (B) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year.

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

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

“(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

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

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

“(3) PAYMENTS UNDER THE CONTRACT.—

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

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

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

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

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

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

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

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

“(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE CONTRACT.—An eligible entity that sub-

mitted a bid to offer a Medicare Prescription Drug plan for an area for a year under section 1860D-12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D-12 for the year.

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

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

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

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

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

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

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

“COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG COVERAGE PREMIUMS

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

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

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

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

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

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

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

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

“COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

“SEC. 1860D-15. (a) COMPUTATION.—

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

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

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

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

“PAYMENTS TO ELIGIBLE ENTITIES

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

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

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

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

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

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

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

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

“(III) the number of prescriptions; and

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

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

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

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

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

“(2) ADJUSTMENT OF PAYMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

“(3) ESTABLISHMENT OF ALLOWABLE COSTS.—

“(A) IN GENERAL.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug

plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year, adjusted under subparagraph (B)(ii).

“(B) REPRICING OF COSTS.—

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

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

“(4) ESTABLISHMENT OF RISK CORRIDORS.—

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

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

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

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

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

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

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

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

“(I) such target amount; and

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

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

“(I) such target amount; and

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

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

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

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

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

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

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

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

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

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

“(I) for 2006 and 2007, 5.0 percent;

“(II) for 2008 through 2011, 10 percent

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

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

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

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

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

“(7) DISCLOSURE OF INFORMATION.—

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

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

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

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

“(c) STABILIZATION RESERVE FUND.—

“(1) ESTABLISHMENT.—

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

ties in contract year 2008 and subsequent contract years in accordance with paragraph (3).

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

“(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(e) PAYMENT TERMS.—

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

payments are made under section 1853(a) (relating to payments to Medicare Advantage organizations).

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

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

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

“COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(B) the sum of—

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

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

“COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

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

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

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

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

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

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

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

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

“SEC. 1860D-19. (a) AMOUNT OF SUBSIDIES.—

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

“(A) section 1860D-17 shall be applied—

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

“(ii) in subsection (a)(3)(B), by substituting ‘the amount of the monthly plan premium

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

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

“(C) section 1860D-6(c)(2) shall be applied by substituting ‘2.5 percent’ for ‘50 percent’ each place it appears;

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

“(E) section 1860D-6(c)(4)(A) shall be applied by substituting ‘2.5 percent’ for ‘10 percent’.

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

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

“(A) section 1860D-17 shall be applied—

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

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

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

“(C) section 1860D-6(c)(2) shall be applied by substituting ‘5.0 percent’ for ‘50 percent’ each place it appears;

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

“(E) section 1860D-6(c)(4)(A) shall be applied by substituting ‘2.5 percent’ for ‘10 percent’.

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

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

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

“(i) section 1860D-17 shall be applied—

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

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

“(ii) the annual deductible applicable under section 1860D-6(c)(1)—

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

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

“(iii) section 1860D-6(c)(2) shall be applied by substituting ‘10.0 percent’ for ‘50 percent’ each place it appears;

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

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

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

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

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

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

“(4) DEFINITIONS.—In this part:

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

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

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

“(iii) is not—

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

“(II) a qualifying individual; or

“(III) a dual eligible individual.

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

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

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

“(iii) is not—

“(I) a qualified medicare beneficiary;

“(II) a qualifying individual; or

“(III) a dual eligible individual.

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

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

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

“(iii) is not—

“(I) a qualified medicare beneficiary;

“(II) a specified low-income medicare beneficiary; or

“(III) a dual eligible individual.

“(D) SUBSIDY-ELIGIBLE INDIVIDUAL.—Subject to subparagraph (H), the term ‘subsidy-eligible individual’ means an individual—

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

“(ii) whose income is less than 160 percent of the poverty line; and

“(iii) who is not—

“(I) a qualified medicare beneficiary;

“(II) a specified low-income medicare beneficiary;

“(III) a qualifying individual; or

“(IV) a dual eligible individual.

“(E) DUAL ELIGIBLE INDIVIDUAL.—

“(i) IN GENERAL.—The term ‘dual eligible individual’ means an individual who is—

“(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that is not less than the medical assistance provided to an individual described in section 1902(a)(10)(A)(i) and includes covered outpatient drugs (as such term is defined for purposes of section 1927); and

“(II) entitled to benefits under part A and enrolled under part B.

“(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

“(F) POVERTY LINE.—The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(G) ELIGIBILITY DETERMINATIONS.—Beginning on November 1, 2005, the determination of whether an individual residing in a State is an individual described in subparagraph (A), (B), (C), (D), or (E) and, for purposes of paragraph (3), the amount of an individual’s income, shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

“(H) NONAPPLICATION TO DUAL ELIGIBLE INDIVIDUALS AND TERRITORIAL RESIDENTS.—In the case of an individual who is a dual eligible individual or an individual who is not a resident of the 50 States or the District of Columbia—

“(i) the subsidies provided under this section shall not apply; and

“(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with section 1935 under the State medicaid program under title XIX.

“(b) RULES IN APPLYING COST-SHARING SUBSIDIES.—Nothing in this section shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D-6(a)(2).

“(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall establish a process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan—

“(1) the Administrator provides for a notification of the eligible entity or MedicareAdvantage organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

“(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

“(3) the Administrator periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

“(d) RELATION TO MEDICAID PROGRAM.—For provisions providing for eligibility determinations and additional Federal payments for expenditures related to providing prescription drug coverage for dual eligible individuals and territorial residents under the medicaid program, see section 1935.

“REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD

“SEC. 1860D-20. (a) REINSURANCE PAYMENTS.—

“(1) IN GENERAL.—Subject to section 1860D-21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D-6(c)(4)(B) for the year.

“(2) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

“(b) NOTIFICATION OF SPENDING UNDER THE PLAN FOR COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD.—

“(1) IN GENERAL.—Each qualifying entity shall notify the Administrator of the following with respect to a qualifying covered individual for a coverage year:

“(A) TOTAL ACTUAL COSTS.—The total amount (if any) of costs that the qualifying entity incurred in providing prescription drug coverage for the individual in the year after the individual had reached the annual out-of-pocket threshold specified in section 1860D-6(c)(4)(B) for the year.

“(B) ACTUAL COSTS FOR SPECIFIC DRUGS.—With respect to the total amount under subparagraph (A) for the year, a breakdown of—

“(i) each covered drug that constitutes a portion of such amount;

“(ii) the negotiated price for the qualifying entity for each such drug;

“(iii) the number of prescriptions; and

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

“(2) CERTAIN EXPENSES NOT INCLUDED.—The amounts under subparagraphs (A) and (B)(ii) of paragraph (1) may not include—

“(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A); or

“(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D-6(a)(2).

“(3) RESTRICTION ON USE OF INFORMATION.—The restriction specified in section 1860D-

16(b)(7)(B) shall apply to information disclosed or obtained pursuant to the provisions of this section.

“(c) REINSURANCE PAYMENT AMOUNT.—

“(1) IN GENERAL.—The reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year is an amount equal to 80 percent of the allowable costs (as specified in paragraph (2)) incurred by the qualifying entity with respect to the individual and year.

“(2) ALLOWABLE COSTS.—

“(A) IN GENERAL.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year, adjusted under subparagraph (B).

“(B) REPRICING OF COSTS IF ACTUAL COSTS EXCEED AVERAGE COSTS.—The Administrator shall reduce the amount described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under subsection (b)(1)(B)) that are greater than the average cost for the covered drug for the year (as determined under section 1860D-16(b)(3)(A)).

“(d) PAYMENT METHODS.—

“(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator’s best estimate of amounts that will be payable after obtaining all of the information.

“(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

“(e) DEFINITIONS.—In this section:

“(1) COVERAGE YEAR.—The term ‘coverage year’ means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

“(2) QUALIFYING COVERED INDIVIDUAL.—The term ‘qualifying covered individual’ means an individual who—

“(A) is enrolled in this part and in a Medicare Prescription Drug plan;

“(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage); or

“(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

“(3) QUALIFYING ENTITY.—The term ‘qualifying entity’ means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

“(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

“(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

“(C) The sponsor of a qualified retiree prescription drug plan.

“(4) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

“(A) IN GENERAL.—The term ‘qualified retiree prescription drug plan’ means employment-based retiree health coverage if, with respect to a qualifying covered individual

who is covered under the plan, the following requirements are met:

“(i) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

“(ii) DISCLOSURE OF INFORMATION.—The sponsor complies with the requirements described in clauses (i) and (ii) of section 1860D-16(b)(7)(A).

“(B) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term ‘employment-based retiree health coverage’ means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

“(5) SPONSOR.—The term ‘sponsor’ means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

“DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

“SEC. 1860D-21. (a) DIRECT SUBSIDY.—

“(1) IN GENERAL.—The Administrator shall provide for the payment to a sponsor of a qualified retiree prescription drug plan (as defined in section 1860D-20(e)(4)) for each qualifying covered individual (described in subparagraph (C) of section 1860D-20(e)(2)) enrolled in the plan for each month for which such individual is so enrolled.

“(2) AMOUNT OF PAYMENT.—

“(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the direct subsidy percent determined for the year of the monthly national average premium for the area for the year (determined under section 1860D-15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D-11.

“(B) DIRECT SUBSIDY PERCENT.—For purposes of subparagraph (A), the term ‘direct subsidy percent’ means the percentage equal to—

“(i) 100 percent; minus

“(ii) the applicable percent for the year (as determined under section 1860D-17(c)).

“(b) PAYMENT METHODS.—

“(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator’s best estimate of amounts that will be payable after obtaining all of the information.

“(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

“Subpart 3—Miscellaneous Provisions

“PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

“SEC. 1860D-25. (a) ESTABLISHMENT.—

“(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the ‘Prescription Drug Account’ (in this section referred to as the ‘Account’).

“(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the Account as provided in this part.

“(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

“(b) PAYMENTS FROM ACCOUNT.—

“(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

“(A) payments to eligible entities under section 1860D-16;

“(B) payments under 1860D-19 for low-income subsidy payments for cost-sharing;

“(C) reinsurance payments under section 1860D-20;

“(D) payments to sponsors of qualified retiree prescription drug plans under section 1860D-21;

“(E) payments to Medicare Advantage organizations for the provision of qualified prescription drug coverage under section 1858A(c); and

“(F) payments with respect to administrative expenses under this part in accordance with section 201(g).

“(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

“(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments and transfers made from the Account in the year.

“OTHER RELATED PROVISIONS

“SEC. 1860D-26. (a) RESTRICTION ON ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—

“(1) IN GENERAL.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that is a sponsor (as defined in paragraph (5) of section 1860D-20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section), notwithstanding any other provision of this part and in accordance with regulations of the Administrator, the entity offering the plan may restrict the enrollment of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

“(2) LIMITATION.—The sponsor of the employment-based retiree health coverage described in paragraph (1) may not offer enrollment in the Medicare Prescription Drug plan described in such paragraph based on the health status of eligible beneficiaries enrolled for such coverage.

“(b) COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

“(1) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a Medicare Advantage organization offering a Medicare Advantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), may enter into an agreement with a State pharmaceutical assistance program described in paragraph (2) to coordinate the coverage provided under the plan with the assistance provided under the State pharmaceutical assistance program.

“(2) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DESCRIBED.—For purposes of paragraph (1), a State pharmaceutical assistance program described in this paragraph is a program that has been established pursuant to a waiver under section 1115 or otherwise.

“(c) REGULATIONS TO CARRY OUT THIS PART.—

“(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment.

“(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).”

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)— (A) by striking “and” before “such amounts”; and

(B) by inserting before the period the following: “, and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D-25”;

(2) in subsection (g), by inserting after “by this part,” the following: “the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund).”;

(3) in subsection (h), by inserting after “1840(d)” the following: “and sections 1860D-18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund).”;

(4) in subsection (i), by inserting after “section 1840(b)(1)” the following: “, sections 1860D-18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund).”.

(c) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

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

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Center for Medicare Choices (as established under section 1808 of the Social Security Act, as added by section 301(a)) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the Medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2005, the Administrator of the Center for Medicare Choices shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

“(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

“(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

“(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE UNDER PART D.—

“(A) IN GENERAL.—The issuer of a medicare supplemental policy—

“(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’ (including the benefit package classified as ‘F’ with a high deductible feature, as described in subsection (p)(11)), or ‘G’ (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

“(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

“(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

“(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

“(i) enrolls in the medicare prescription drug delivery program under part D; and

“(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ‘H’, ‘I’, or ‘J’ (including the benefit package classified as ‘J’ with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

“(C) ENFORCEMENT.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

“(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

“(A) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

“(B) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D.”.

(b) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under

part D of such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

SEC. 104. MEDICARE AND OTHER AMENDMENTS RELATED TO LOW-INCOME BENEFICIARIES.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking “and” at the end of paragraph (64);

(2) by striking the period at the end of paragraph (65) and inserting “; and”; and

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

“(66) provide for making eligibility determinations under section 1935(a).”.

(b) NEW SECTION.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

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

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

“SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

“SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall satisfy the following:

“(1) DETERMINATION OF ELIGIBILITY FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—For purposes of section 1807A, submit to the Secretary an eligibility plan under which the State—

“(A) establishes eligibility standards consistent with the provisions of that section;

“(B) establishes procedures for providing presumptive eligibility for eligible low-income beneficiaries (as defined in section 1807A(i)(2)) under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

“(C) makes determinations of eligibility and income for purposes of identifying eligible low-income beneficiaries (as so defined) under that section; and

“(D) communicates to the Secretary determinations of eligibility or discontinuation of eligibility under that section for purposes of notifying prescription drug card sponsors under that section of the identity of eligible medicare low-income beneficiaries.

“(2) DETERMINATION OF ELIGIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER PART D OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Beginning November 1, 2005, for purposes of section 1860D–19—

“(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with such section;

“(B) establish procedures for providing presumptive eligibility for individuals eligible for subsidies under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

“(C) inform the Administrator of the Center for Medicare Choices of such determinations in cases in which such eligibility is established; and

“(D) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

“(3) AGREEMENT TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY

FIELD OFFICES.—Enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as information and enrollment sites for making the eligibility determinations required under paragraphs (1) and (2).

“(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

“(1) ENHANCED MATCH FOR ELIGIBILITY DETERMINATIONS.—Subject to paragraphs (2) and (4), with respect to calendar quarters beginning on or after January 1, 2004, the amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under section 1903(a)(7) except that, in applying such section with respect to such expenditures incurred for—

“(A) such calendar quarters occurring in fiscal year 2004 or 2005, ‘75 per cent’ shall be substituted for ‘50 per centum’;

“(B) calendar quarters occurring in fiscal year 2006, ‘70 per cent’ shall be substituted for ‘50 per centum’;

“(C) calendar quarters occurring in fiscal year 2007, ‘65 per cent’ shall be substituted for ‘50 per centum’; and

“(D) calendar quarters occurring in fiscal year 2008 or any fiscal year thereafter, ‘60 per cent’ shall be substituted for ‘50 per centum’.

“(2) 100 PERCENT MATCH FOR ELIGIBILITY DETERMINATIONS FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In the case of amounts expended by a State on or after November 1, 2005, to determine whether an individual is a subsidy-eligible individual for purposes of section 1860D–19, such expenditures shall be reimbursed under section 1903(a)(7) by substituting ‘100 per cent’ for ‘50 per centum’.

“(3) ENHANCED MATCH FOR UPDATES OR IMPROVEMENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With respect to calendar quarters occurring in fiscal year 2004, 2005, or 2006, the Secretary, in addition to amounts otherwise paid under section 1903(a), shall pay to each State which has a plan approved under this title, for each such quarter an amount equal to 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, acquisition, or installation of improved eligibility determination systems (including hardware and software for such systems) in order to carry out the requirements of subsection (a) and section 1807A(h)(1). No payment shall be made to a State under the preceding sentence unless the State’s improved eligibility determination system—

“(A) satisfies such standards for improvement as the Secretary may establish; and

“(B) complies, and is compatible, with the standards established under part C of title XI and any regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

“(4) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate expenditures described in paragraph (1), (2), or (3) that may otherwise be made for similar eligibility determinations or expenditures.

“(c) FEDERAL PAYMENT OF MEDICARE PART B PREMIUM FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS.—

“(1) IN GENERAL.—Subject to paragraph (4), in the case of a State that provides medical assistance for covered drugs (as such term is defined in section 1860D(a)(2)) to dual eligible individuals under this title that satisfies the minimum standards described in paragraph (2), the Secretary shall be responsible in accordance with section 1841(f)(2) for paying 100 percent of the medicare cost-sharing described in section 1905(p)(3)(A)(ii) (relating to premiums under section 1839) for individuals—

“(A) who are dual eligible individuals or qualified medicare beneficiaries; and

“(B) whose family income is at least 74 percent, but not more than 100 percent, of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

“(2) MINIMUM STANDARDS DESCRIBED.—For purposes of paragraph (1), the minimum standards described in this paragraph are the following:

“(A) In providing medical assistance for dual eligible individuals for such covered drugs, the State satisfies the requirements of this title (including limitations on cost-sharing imposed under section 1916) applicable to the provision of medical assistance for prescribed drugs to dual eligible individuals.

“(B) In providing medical assistance for dual eligible individuals for such covered drugs, the State provides such individuals with beneficiary protections that the Secretary determines are equivalent to the beneficiary protections applicable under section 1860D-5 to eligible entities offering a Medicare Prescription Drug plan under part D of title XVIII.

“(C) In providing medical assistance for dual eligible individuals for such covered drugs, the State does not impose a limitation on the number of prescriptions an individual may have filled.

“(3) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State for purposes of providing medical assistance for covered drugs (as such term is defined in section 1860D(a)(2)) to dual eligible individuals that satisfies the minimum standards described in paragraph (2).

“(4) LIMITATION.—Paragraph (1) shall not apply to any State before January 1, 2006.

“(d) FEDERAL PAYMENT OF MEDICARE PART A COST-SHARING FOR CERTAIN STATES.—

“(1) IN GENERAL.—Subject to paragraph (2), in the case of a State that, as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, provides medical assistance for individuals described in section 1902(a)(10)(A)(ii)(X), the Secretary shall be responsible in accordance with section 1817(g)(2), for paying 100 percent of the medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3) (relating to coinsurance and deductibles established under title XVIII) for the individuals provided medical assistance under section 1902(a)(10)(A)(ii)(X), but only—

“(A) with respect to such medicare cost-sharing that is incurred under part A of title XVIII; and

“(B) for so long as the State elects to provide medical assistance under section 1902(a)(10)(A)(ii)(X).

“(2) LIMITATION.—Paragraph (1) shall not apply to any State before January 1, 2006.

“(e) TREATMENT OF TERRITORIES.—

“(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

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

“(B) if the State establishes a plan described in paragraph (2), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be further increased by the amount specified in paragraph (3).

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

“(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to individuals described in subparagraph (A), (B), (C), or (D) of section 1860D-19(a)(3); and

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

“(3) INCREASED AMOUNT.—

“(A) IN GENERAL.—The amount specified in this paragraph for a State for a fiscal year is equal to the product of—

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

“(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

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

“(i) the last 3 quarters of fiscal year 2006, is equal to \$22,500,000;

“(ii) fiscal year 2007, is equal to \$30,000,000; and

“(iii) any subsequent fiscal year, is equal to the aggregate amount specified in this subparagraph for the previous fiscal year increased by the annual percentage increase specified in section 1860D-6(c)(5) for the calendar year beginning in such fiscal year.

“(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State described in paragraph (1) for purposes of providing medical assistance described in paragraph (2)(A).

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

“(f) DEFINITIONS.—For purposes of this section, the terms ‘qualified medicare beneficiary’, ‘subsidy-eligible individual’, and ‘dual eligible individual’ have the meanings given such terms in subparagraphs (A), (D), and (E), respectively, of section 1860D-19(a)(4).”

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

(3) TRANSFER OF FEDERALLY ASSUMED PORTIONS OF MEDICARE COST-SHARING.—

(A) TRANSFER OF ASSUMPTION OF PART B PREMIUM FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS TO THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841(f) (42 U.S.C. 1395t(f)) is amended—

(i) by inserting “(1)” after “(f)”; and

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

“(2) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Treasury amounts which the Secretary of Health and Human Services shall have certified are equivalent to the amounts determined under section 1935(c)(1) with respect to all States for a fiscal year.”

(B) TRANSFER OF ASSUMPTION OF PART A COST-SHARING FOR CERTAIN STATES.—Section 1817(g) (42 U.S.C. 1395(g)) is amended—

(i) by inserting “(1)” after “(g)”; and

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

“(2) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Treasury amounts which the Secretary of Health and Human Services shall have certified are equivalent to the amounts determined under section 1935(d)(1) with respect to certain States for a fiscal year.”

(4) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r-8(c)(1)(C)(i)), as amended by section 111(b), is amended—

(A) by striking “and” at the end of subclause (IV);

(B) by striking the period at the end of subclause (V) and inserting “; and”; and

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

“(VI) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a

Medicare Advantage plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D-20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3)).”

(c) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH 2008.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

“(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan.”

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(c) (42 U.S.C. 1396u-3(c)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking “and” at the end;

(ii) in subparagraph (E)—

(I) by striking “fiscal year 2002” and inserting “each of fiscal years 2002 through 2008”; and

(II) by striking the period and inserting “; and”; and

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

“(F) the first quarter of fiscal year 2009, \$100,000,000.”; and

(B) in paragraph (2)(A), by striking “the sum of” and all that follows through “1902(a)(10)(E)(iv)(II) in the State; to” and inserting “twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to”.

(d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b-14) is amended—

(1) in the section heading, by inserting “AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII” after “COST-SHARING”; and

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting “for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies under section 1860D-19” before the semicolon; and

(ii) in subparagraph (B), by inserting “, program, and subsidies” after “medical assistance”; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting “, the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D-19” after “assistance”; and

(ii) in subparagraph (A), by striking “such eligibility” and inserting “eligibility for medicare cost-sharing under the medicare program”; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting “, for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D-19” after “1933”; and

(B) in paragraph (2), by inserting “, program, and subsidies” after “medical assistance”.

(e) REPORT REGARDING VOLUNTARY ENROLLMENT OF DUAL ELIGIBLE INDIVIDUALS IN PART D.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains such recommendations for legislation as the Secretary determines are necessary in order to establish a voluntary option for dual eligible individuals (as defined in 1860D–19(a)(4)(E) of the Social Security Act (as added by section 101)) to enroll under part D of title XVIII of such Act for prescription drug coverage.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking “17” and inserting “19”; and

(B) in paragraph (2)(B), by inserting “experts in the area of pharmacology and prescription drug benefit programs,” after “other health professionals.”.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2005.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

“(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.”.

SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING AND DRUG UTILIZATION.

(a) STUDY.—The Secretary shall study on an ongoing basis variations in spending and drug utilization under part D of title XVIII of the Social Security Act for covered drugs to determine the impact of such variations on premiums imposed by eligible entities offering Medicare Prescription Drug plans under that part. In conducting such study, the Secretary shall examine the impact of geographic adjustments of the monthly national average premium under section 1860D–15 of such Act on—

(1) maximization of competition under part D of title XVIII of such Act; and

(2) the ability of eligible entities offering Medicare Prescription Drug plans to contain costs for covered drugs.

(b) REPORT.—Beginning with 2007, the Secretary shall submit annual reports to Congress on the study required under subsection (a).

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sections:

“MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

“SEC. 1807. (a) ESTABLISHMENT.—There is established a medicare prescription drug discount card endorsement program under which the Secretary shall—

“(1) endorse prescription drug discount card programs offered by prescription drug card sponsors that meet the requirements of this section; and

“(2) make available to eligible beneficiaries information regarding such endorsed programs.

“(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

“(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures—

“(i) for identifying eligible beneficiaries; and

“(ii) under which such beneficiaries may make an election to enroll in any prescription drug discount card program endorsed under this section and disenroll from such a program.

“(B) LIMITATION.—An eligible beneficiary may not be enrolled in more than 1 prescription drug discount card program at any time.

“(2) ENROLLMENT FEES.—

“(A) IN GENERAL.—A prescription drug card sponsor may charge an annual enrollment fee to each eligible beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

“(B) AMOUNT.—No enrollment fee charged under subparagraph (A) may exceed \$25.

“(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is the same for all eligible medicare beneficiaries enrolled in the program.

“(D) COLLECTION.—Any enrollment fee shall be collected by the prescription drug card sponsor.

“(c) PROVIDING INFORMATION TO ELIGIBLE BENEFICIARIES.—

“(1) PROMOTION OF INFORMED CHOICE.—

“(A) BY THE SECRETARY.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs. Such dissemination shall be coordinated with the dissemination of educational information on other medicare options.

“(B) BY PRESCRIPTION DRUG CARD SPONSORS.—Each prescription drug card sponsor shall make available to each eligible beneficiary (through the Internet and otherwise) information—

“(i) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries, including information on enrollment fees, negotiated prices for prescription drugs charged to beneficiaries, and services relating to prescription drugs offered under the program;

“(ii) on how any formulary used by such sponsor functions.

“(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1–800–MEDICARE toll free telephone number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established under this section and prescription drug discount card programs endorsed under such program.

“(d) BENEFICIARY PROTECTIONS.—

“(1) IN GENERAL.—Each prescription drug discount card program endorsed under this

section shall meet such requirements as the Secretary identifies to protect and promote the interest of eligible beneficiaries, including requirements that—

“(A) relate to appeals by eligible beneficiaries and marketing practices; and

“(B) ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

“(2) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

“(3) QUALITY ASSURANCE.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall have in place adequate procedures for assuring that quality service is provided to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor.

“(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(5) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under subsection (b)(2)(A).

“(6) PRICES.—

“(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor may not recommend switching an eligible beneficiary to a drug with a higher negotiated price absent a recommendation by a licensed health professional that there is a clinical indication with respect to the patient for such a switch.

“(B) PRICE STABILITY.—Negotiated prices charged for prescription drugs covered under a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

“(e) PRESCRIPTION DRUG BENEFITS.—

“(1) IN GENERAL.—Each prescription drug card sponsor may only provide benefits that relate to prescription drugs (as defined in subsection (i)(2)) under a prescription drug discount card program endorsed under this section.

“(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

“(A) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide eligible beneficiaries who enroll in a prescription drug discount card program offered by such sponsor that is endorsed under this section with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries.

“(B) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The requirements of section 1927 relating to manufacturer best price shall

not apply to the negotiated prices for prescription drugs made available under a prescription drug discount card program endorsed under this section.

“(C) GUARANTEED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures to ensure that eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

“(D) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card program if the program excludes the drug under a formulary.

“(3) BENEFICIARY SERVICES.—Each prescription drug discount card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

“(4) DISCOUNT CARDS.—Each prescription drug card sponsor shall issue a card to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor that the beneficiary may use to obtain benefits under the program.

“(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT AND APPROVAL.—

“(1) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

“(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to endorse the prescription drug discount card program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

“(g) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

“(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

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

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

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

“(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

“(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined by the Secretary), although not nec-

essarily for all drugs within such categories and classes.

“(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutic categories and classes.

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

“(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and pharmacies.

“(h) FRAUD AND ABUSE PREVENTION.—

“(1) IN GENERAL.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

“(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions and may revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

“(3) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed \$10,000 for any violation of this section. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(4) REPORTING TO SECRETARY.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall report information relating to program performance, use of prescription drugs by eligible beneficiaries enrolled in the program, financial information of the sponsor, and such other information as the Secretary may specify. The Secretary may not disclose any proprietary data reported under this paragraph.

“(5) DRUG UTILIZATION REVIEW.—The Secretary may use claims data from parts A and B for purposes of conducting a drug utilization review program.

“(i) DEFINITIONS.—In this section:

“(1) ELIGIBLE BENEFICIARY.—

“(A) IN GENERAL.—The term ‘eligible beneficiary’ means an individual who—

“(i) is entitled to, or enrolled for, benefits under part A and enrolled under part B; and

“(ii) is not a dual eligible individual (as defined in subparagraph (B)).

“(B) DUAL ELIGIBLE INDIVIDUAL.—

“(i) IN GENERAL.—The term ‘dual eligible individual’ means an individual who is—

“(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that is not less than the medical assistance provided to an individual described in section 1902(a)(10)(A)(i) and includes covered outpatient drugs (as such term is defined for purposes of section 1927); and

“(II) entitled to benefits under part A and enrolled under part B.

“(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

“(2) PRESCRIPTION DRUG.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘prescription drug’ means—

“(i) a drug that may be dispensed only upon a prescription and that is described in

clause (i) or (ii) of subparagraph (A) of section 1927(k)(2); or

“(ii) a biological product or insulin described in subparagraph (B) or (C) of such section,

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

“(B) EXCLUSIONS.—The term ‘prescription drug’ does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

“(3) NEGOTIATED PRICE.—The term ‘negotiated price’ includes all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations.

“(4) PRESCRIPTION DRUG CARD SPONSOR.—The term ‘prescription drug card sponsor’ means any entity with demonstrated experience and expertise in operating a prescription drug discount card program, an insurance program that provides coverage for prescription drugs, or a similar program that the Secretary determines to be appropriate to provide eligible beneficiaries with the benefits under a prescription drug discount card program endorsed by the Secretary under this section, including—

“(A) a pharmaceutical benefit management company;

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

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

“(D) any other entity; or

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

“TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

“SEC. 1807A. (a) ESTABLISHMENT.—

“(1) IN GENERAL.—There is established a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card that has been endorsed by the Secretary under section 1807 under which such sponsors shall offer a prescription drug assistance card program to eligible low-income beneficiaries in accordance with the requirements of this section.

“(2) APPLICATION OF DISCOUNT CARD PROVISIONS.—Except as otherwise provided in this section, the provisions of section 1807 shall apply to the program established under this section.

“(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

“(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(1)(A)(ii) shall apply for purposes of this section.

“(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

“(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card

sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

“(2) WAIVER OF ENROLLMENT FEES.—

“(A) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

“(B) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

“(C) ADDITIONAL BENEFICIARY PROTECTIONS.—

“(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall—

“(A) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

“(B) notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the grievance and appeals processes under the program.

“(2) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—For purposes of determining whether convenient access has been provided under section 1807(d)(2) with respect to eligible low-income beneficiaries enrolled in a prescription drug assistance card program, the Secretary may only make a determination that such access has been provided if an appropriate arrangement is in place for eligible low-income beneficiaries who are in a long-term care facility (as defined by the Secretary) to receive prescription drug benefits under the program.

“(3) COORDINATION OF BENEFITS.—

“(A) IN GENERAL.—The Secretary shall establish procedures under which eligible low-income beneficiaries who are enrolled for coverage described in subparagraph (B) and enrolled in a prescription drug assistance card program have access to the prescription drug benefits available under such program.

“(B) COVERAGE DESCRIBED.—Coverage described in this subparagraph is as follows:

“(i) Coverage of prescription drugs under a State pharmaceutical assistance program.

“(ii) Enrollment in a Medicare+Choice plan under part C.

“(4) GRIEVANCE MECHANISM.—Each prescription drug card sponsor with a contract under this section shall provide in accordance with section 1852(f) meaningful procedures for hearing and resolving grievances between the prescription drug card sponsor (including any entity or individual through which the prescription drug card sponsor provides covered benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

“(5) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—

“(A) IN GENERAL.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(B) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug assistance card program

offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

“(C) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

“(6) APPEALS.—

“(A) IN GENERAL.—Subject to subparagraph (B), a prescription drug card sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in a similar manner (as determined by the Secretary) as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(B) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

“(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The prescription drug card sponsor must have, as part of the appeals process under this paragraph, a process for timely appeals for denials of coverage based on the application of the formulary.

“(d) PRESCRIPTION DRUG BENEFITS.—

“(1) IN GENERAL.—Subject to paragraph (5), all the benefits available under a prescription drug discount card program offered by a prescription drug card sponsor and endorsed under section 1807 shall be available to eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor.

“(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—

“(A) \$600 ANNUAL ASSISTANCE.—Subject to subparagraphs (B) and (C) and paragraph (5), each prescription drug card sponsor with a contract under this section shall provide coverage for the first \$600 of expenses for prescription drugs incurred during each calendar year by an eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor.

“(B) COINSURANCE.—

“(i) IN GENERAL.—The prescription drug card sponsor shall determine an amount of coinsurance to collect from each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor for which coverage is available under subparagraph (A).

“(ii) AMOUNT.—The amount of coinsurance collected under clause (i) shall be at least 10 percent of the negotiated price of each prescription drug dispensed to an eligible low-income beneficiary.

“(iii) CONSTRUCTION.—Amounts collected under clause (1) shall not be counted against the total amount of coverage available under subparagraph (A).

“(C) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible low-income beneficiary is not enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor with a contract under this section, the amount of assistance available under subparagraph (A) shall be reduced by \$50.

“(D) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—The dollar amount of coverage described in subparagraph (A) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

“(E) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Secretary may waive such requirements of this section and section 1807 as may be necessary to ensure that each eligible low-income beneficiary has access to the assistance described in subparagraph (A).

“(3) ADDITIONAL DISCOUNTS.—A prescription drug card sponsor with a contract under this section shall provide each eligible low-income beneficiary enrolled in a prescription drug assistance program offered by the sponsor with access to negotiated prices that reflect a minimum average discount of at least 20 percent of the average wholesale price for prescription drugs covered under that program.

“(4) ASSISTANCE CARDS.—Each prescription drug card sponsor shall permit eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor to use the discount card issued under section 1807(e)(4) to obtain benefits under the program.

“(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible low-income beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug assistance card program if the program excludes the drug under a formulary and such exclusion is not successfully resolved under paragraph (4), (5), or (6) of subsection (c).

“(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE CARD PROGRAMS.—

“(1) IN GENERAL.—Each prescription drug card sponsor shall—

“(A) process claims made by eligible low-income beneficiaries;

“(B) negotiate with brand name and generic prescription drug manufacturers and others for low prices on prescription drugs;

“(C) track individual beneficiary expenditures in a format and periodicity specified by the Secretary; and

“(D) perform such other functions as the Secretary may assign.

“(2) DATA EXCHANGES.—Each prescription drug card sponsor shall receive data exchanges in a format specified by the Secretary and shall maintain real-time beneficiary files.

“(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The prescription drug card sponsor offering the prescription drug assistance card program shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the eligible low-income beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest priced generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy or other dispenser.

“(f) SUBMISSION OF BIDS AND AWARDING OF CONTRACTS.—

“(1) SUBMISSION OF BIDS.—Each prescription drug card sponsor that seeks to offer a prescription drug assistance card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

“(2) AWARDING OF CONTRACTS.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to award a contract to the prescription drug card sponsor offering the program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

“(3) NUMBER OF CONTRACTS.—There shall be no limit on the number of prescription drug card sponsors that may be awarded contracts under paragraph (2).

“(4) CONTRACT PROVISIONS.—

“(A) DURATION.—A contract awarded under paragraph (2) shall be for the lifetime of the program under this section.

“(B) WITHDRAWAL.—A prescription drug card sponsor that desires to terminate the contract awarded under paragraph (2) may terminate such contract without penalty if such sponsor gives notice—

“(i) to the Secretary 90 days prior to the termination of such contract; and

“(ii) to each eligible low-income beneficiary that is enrolled in a prescription drug assistance card program offered by such sponsor 60 days prior to such termination.

“(C) SERVICE AREA.—The service area under the contract shall be the same as the area served by the prescription drug card sponsor under section 1807.

“(5) SIMULTANEOUS APPROVAL OF DISCOUNT CARD AND ASSISTANCE PROGRAMS.—A prescription drug card sponsor may submit an application for endorsement under section 1807 as part of the bid submitted under paragraph (1) and the Secretary may approve such application at the same time as the Secretary awards a contract under this section.

“(g) PAYMENTS TO PRESCRIPTION DRUG CARD SPONSORS.—

“(1) IN GENERAL.—The Secretary shall pay to each prescription drug card sponsor offering a prescription drug assistance card program in which an eligible low-income beneficiary is enrolled an amount equal to the amount agreed to by the Secretary and the sponsor in the contract awarded under subsection (f)(2).

“(2) PAYMENT FROM PART B TRUST FUND.—The costs of providing benefits under this section shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

“(h) ELIGIBILITY DETERMINATIONS MADE BY STATES; PRESUMPTIVE ELIGIBILITY.—States shall perform the functions described in section 1935(a)(1).

“(i) APPROPRIATIONS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 such sums as may be necessary to carry out the program under this section.

“(j) DEFINITIONS.—In this section:

“(1) ELIGIBLE BENEFICIARY; NEGOTIATED PRICE; PRESCRIPTION DRUG.—The terms ‘eligible beneficiary’, ‘negotiated price’, and ‘prescription drug’ have the meanings given those terms in section 1807(i).

“(2) ELIGIBLE LOW-INCOME BENEFICIARY.—The term ‘eligible low-income beneficiary’ means an individual who—

“(A) is an eligible beneficiary (as defined in section 1807(i)); and

“(B) is described in clause (iii) or (iv) of section 1902(a)(10)(E) or in section 1905(p)(1).

“(3) PRESCRIPTION DRUG CARD SPONSOR.—The term ‘prescription drug card sponsor’

has the meaning given that term in section 1807(i), except that such sponsor shall also be an entity that the Secretary determines is—

“(A) is appropriate to provide eligible low-income beneficiaries with the benefits under a prescription drug assistance card program under this section; and

“(B) is able to manage the monetary assistance made available under subsection (d)(2);

“(C) agrees to submit to audits by the Secretary; and

“(D) provides such other assurances as the Secretary may require.

“(4) STATE.—The term ‘State’ has the meaning given such term for purposes of title XIX.”

(b) EXCLUSION OF PRICES FROM DETERMINATION OF BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r-8(c)(1)(C)(i)) is amended—

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

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

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

“(V) any negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.”

(c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE CARD COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking “attributable to the application of section” and inserting “attributable to—

“(1) the application of section”;

(2) by striking the period and inserting “; and”; and

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

“(2) the prescription drug assistance card program under section 1807A.”

(d) REGULATIONS.—

(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) EXEMPTION FROM THE PAPERWORK REDUCTION ACT.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the “Paperwork Reduction Act”).

(e) IMPLEMENTATION; TRANSITION.—

(1) IMPLEMENTATION.—The Secretary shall implement the amendments made by this section in a manner that discounts are available to eligible beneficiaries under section 1807 of the Social Security Act and assistance is available to eligible low-income beneficiaries under section 1807A of such Act not later than January 1, 2004.

(2) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the programs under section 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continue to operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

“PART D—ELECTRONIC PRESCRIBING

“STANDARDS FOR ELECTRONIC PRESCRIBING

“SEC. 1180. (a) STANDARDS.—

“(1) DEVELOPMENT AND ADOPTION.—

“(A) IN GENERAL.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as ‘standards’) to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information.

“(B) CONSULTATION.—In developing and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

“(2) OBJECTIVE.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

“(A) patient safety; and

“(B) the quality of care provided to patients.

“(3) REQUIREMENTS.—Any standards developed or adopted under this part shall comply with the following:

“(A) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—

“(i) IN GENERAL.—Except as provided in clause (ii), the standards require that prescriptions be written and transmitted electronically.

“(ii) EXCEPTIONS.—The standards shall not require a prescription to be written and transmitted electronically—

“(I) in emergency cases and other exceptional circumstances recognized by the Administrator; or

“(II) if the patient requests that the prescription not be transmitted electronically.

If a patient makes a request under subclause (II), no additional charges may be imposed on the patient for making such request.

“(B) PATIENT-SPECIFIC MEDICATION HISTORY, ELIGIBILITY, BENEFIT, AND OTHER PRESCRIPTION INFORMATION.—

“(i) IN GENERAL.—The standards shall accommodate electronic transmittal of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

“(ii) REQUIRED INFORMATION.—The information described in clause (i) shall include the following:

“(I) Information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medication history of the patient that may be relevant to the appropriate prescription for that patient.

“(II) Cost-effective alternatives (if any) to the drug prescribed.

“(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

“(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

“(V) Other information to improve the quality of patient care and to reduce medical errors.

“(C) UNDUE BURDEN.—The standards shall be designed so that, to the extent practicable, the standards do not impose an

undue administrative burden on the practice of medicine, pharmacy, or other health professions.

“(D) COMPATIBILITY WITH ADMINISTRATIVE SIMPLIFICATION AND PRIVACY LAWS.—The standards shall be—

“(i) consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

“(ii) compatible with the standards adopted under part C.

“(4) TRANSFER OF INFORMATION.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

“(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

“(1) IN GENERAL.—The Secretary shall adopt the standards under this part by January 1, 2006.

“(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, review the standards developed or adopted under this part and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

“(c) COMPLIANCE WITH STANDARDS.—

“(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—

“(A) IN GENERAL.—Individuals or entities that transmit or receive electronic medication history, eligibility, benefit and prescription information, shall comply with the standards adopted or modified under this part.

“(B) RELATION TO STATE LAWS.—The standards adopted or modified under this part shall supersede any State law or regulations pertaining to the electronic transmission of medication history, eligibility, benefit and prescription information.

“(2) TIMETABLE FOR COMPLIANCE.—

“(A) INITIAL COMPLIANCE.—

“(i) IN GENERAL.—Not later than 24 months after the date on which an initial standard is adopted under this part, each individual or entity to whom the standard applies shall comply with the standard.

“(ii) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting ‘36 months’ for ‘24 months’.

“(d) CONSULTATION WITH ATTORNEY GENERAL.—The Secretary shall consult with the Attorney General before developing, adopting, or modifying a standard under this part to ensure that the standard accommodates secure electronic transmission of prescriptions for controlled substances in a manner that minimizes the possibility of violations under the Comprehensive Drug Abuse Prevention and Control Act of 1970 and related Federal laws.

“GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION PROGRAMS

“SEC. 1180A. (a) IN GENERAL.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic

prescription programs that comply with the standards adopted or modified under this part.

“(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

“(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.”.

Subtitle D—Other Provisions

SEC. 131. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

“(1) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (INCLUDING THE PRESCRIPTION DRUG ACCOUNT).—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (including the Prescription Drug Account within such Trust Fund), in this subsection referred to as the ‘Trust Funds’. Such report shall include the following information:

“(1) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year, for each of the following amounts:

“(A) MEDICARE BENEFITS.—The amount expended for payment of benefits covered under this title.

“(B) ADMINISTRATIVE AND OTHER EXPENSES.—The amount expended for payments not related to the benefits described in subparagraph (A).

“(2) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph.

“(3) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

“(4) RELATION TO OTHER MEASURES OF GROWTH.—A comparison of the rate of growth of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, to the rate of growth for the same period in—

“(A) the gross domestic product;

“(B) health insurance costs in the private sector;

“(C) employment-based health insurance costs in the public and private sectors; and

“(D) other areas as determined appropriate by the Board of Trustees.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with re-

spect to fiscal years beginning on or after the date of enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction of Congress shall hold hearings on the reports submitted under section 1817(1) of the Social Security Act (as added by subsection (a)).

SEC. 132. TRUSTEES' REPORT ON MEDICARE'S UNFUNDED OBLIGATIONS.

(a) REPORT.—The report submitted under sections 1817(b)(2) and 1841(b)(2) of the Social Security Act (42 U.S.C. 1395i(b)(2) and 1395t(b)(2)) during 2004 shall include an analysis of the total amount of the unfunded obligations of the Medicare program under title XVIII of the Social Security Act.

(b) MATTERS ANALYZED.—The analysis described in subsection (A) shall compare the long-term obligations of the Medicare program to the dedicated funding sources for that program (other than general revenue transfers), including the combined obligations of the Federal Hospital Insurance Trust Fund established under section 1817 of such Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.

Section 1851 (42 U.S.C. 1395w–21) is amended to read as follows:

“ELIGIBILITY, ELECTION, AND ENROLLMENT

“SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREADVANTAGE PLANS.—

“(1) IN GENERAL.—Subject to the provisions of this section, each MedicareAdvantage eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

“(A) through—

“(i) the original Medicare fee-for-service program under parts A and B; and

“(ii) the voluntary prescription drug delivery program under part D; or

“(B) through enrollment in a MedicareAdvantage plan under this part.

“(2) TYPES OF MEDICAREADVANTAGE PLANS THAT MAY BE AVAILABLE.—A MedicareAdvantage plan may be any of the following types of plans of health insurance:

“(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans (with or without point of service options) and plans offered by provider-sponsored organizations (as defined in section 1855(d)).

“(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREADVANTAGE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a MedicareAdvantage medical savings account (MSA).

“(C) PRIVATE FEE-FOR-SERVICE PLANS.—A MedicareAdvantage private fee-for-service plan, as defined in section 1859(b)(2).

“(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—Subject to subparagraph (B), in this title, the term ‘MedicareAdvantage eligible individual’ means an individual who is entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

“(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that plan; and

“(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a ‘MedicareAdvantage eligible individual’ for purposes of electing to continue enrollment in another MedicareAdvantage plan.

“(b) SPECIAL RULES.—

“(1) RESIDENCE REQUIREMENT.—

“(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization only if the plan serves the geographic area in which the individual resides.

“(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost-sharing liability in obtaining such benefits.

“(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—

“(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

“(ii) there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization’s election.

“(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.—

“(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

“(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

“(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan

under title XIX is not eligible to enroll in an MSA plan.

“(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

“(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

“(i) on or after January 1, 2004, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

“(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

“(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

“(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

“(c) PROCESS FOR EXERCISING CHOICE.—

“(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

“(2) COORDINATION THROUGH MEDICAREADVANTAGE ORGANIZATIONS.—

“(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

“(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

“(3) DEFAULT.—

“(A) INITIAL ELECTION.—

“(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

“(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicareAdvantage plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

“(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

“(i) the individual changes the election under this section; or

“(ii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

“(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

“(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

“(2) PROVISION OF NOTICE.—

“(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

“(i) GENERAL INFORMATION.—The general information described in paragraph (3).

“(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicareAdvantage plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

“(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

“(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

“(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

“(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

“(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

“(A) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original medicare fee-for-service program, including—

“(i) covered items and services;

“(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

“(iii) any beneficiary liability for balance billing.

“(B) CATASTROPHIC COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

“(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D-4 with respect to coverage for prescription drugs under the plan.

“(D) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

“(E) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

“(F) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

“(G) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the MedicareAdvantage plan under this part.

“(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicareAdvantage plan for a year, shall include the following:

“(A) BENEFITS.—The benefits covered under the plan, including the following:

“(i) Covered items and services beyond those provided under the original medicare fee-for-service program option.

“(ii) Beneficiary cost-sharing for any items and services described in clause (i) and paragraph (3)(A)(i), including information on the unified deductible under section 1852(a)(1)(C).

“(iii) The maximum limitations on out-of-pocket expenses under section 1852(a)(1)(C).

“(iv) In the case of an MSA plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

“(v) In the case of a MedicareAdvantage private fee-for-service plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

“(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

“(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

“(viii) The organization's coverage of emergency and urgently needed care.

“(ix) The comparative information described in section 1860D-4(b)(2) relating to prescription drug coverage under the plan.

“(B) PREMIUMS.—

“(i) IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.

“(ii) REDUCTIONS.—The reduction in part B premiums, if any.

“(iii) NATURE OF THE PREMIUM FOR ENHANCED MEDICAL BENEFITS.—Whether the MedicareAdvantage monthly premium for enhanced benefits is optional or mandatory.

“(C) SERVICE AREA.—The service area of the plan.

“(D) QUALITY AND PERFORMANCE.—Plan quality and performance indicators for the benefits under the plan (and how such indicators compare to quality and performance indicators under the original medicare fee-for-service program under parts A and B and under the voluntary prescription drug deliv-

ery program under part D in the area involved), including—

“(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area);

“(ii) information on medicare enrollee satisfaction;

“(iii) information on health outcomes; and

“(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

“(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicareAdvantage options and the operation of this part in all areas in which MedicareAdvantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicareAdvantage plans.

“(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

“(7) PROVISION OF INFORMATION.—A MedicareAdvantage organization shall provide the Secretary with such information on the organization and each MedicareAdvantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

“(e) COVERAGE ELECTION PERIODS.—

“(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more MedicareAdvantage plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a MedicareAdvantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

“(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), the following rules shall apply:

“(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

“(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a MedicareAdvantage eligible individual during 2006, during the first 6 months during 2006 in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF 1 CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

“(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of 2007 and each subsequent year, or, if the individual first becomes a MedicareAdvantage eligible individual during 2007 or any subsequent year, during the first 3 months of such year in which the indi-

vidual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF 1 CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

“(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time during 2006 or any subsequent year, in the case of a MedicareAdvantage eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

“(i) to enroll in a MedicareAdvantage plan; or

“(ii) to change the MedicareAdvantage plan in which the individual is enrolled.

“(3) ANNUAL, COORDINATED ELECTION PERIOD.—

“(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

“(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term ‘annual, coordinated election period’ means, with respect to a year before 2003 and after 2006, the month of November before such year and with respect to 2003, 2004, 2005, and 2006, the period beginning on November 15 and ending on December 31 of the year before such year.

“(C) MEDICAREADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicareAdvantage eligible individuals about MedicareAdvantage plans and the election process provided under this section.

“(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform MedicareAdvantage eligible individuals about the availability of MedicareAdvantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

“(4) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may discontinue an election of a MedicareAdvantage plan offered by a MedicareAdvantage organization other than during an annual, coordinated election period and make a new election under this section if—

“(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

“(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

“(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

“(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

“(i) the organization offering the plan substantially violated a material provision of the organization’s contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

“(ii) the organization (or an agent or other entity acting on the organization’s behalf) materially misrepresented the plan’s provisions in marketing the plan to the individual; or

“(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective on and after January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a MedicareAdvantage plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

“(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

“(A) may elect an MSA plan only during—

“(i) an initial open enrollment period described in paragraph (1);

“(ii) an annual, coordinated election period described in paragraph (3)(B); or

“(iii) the month of November 1998;

“(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (i) or (ii) of subparagraph (A) and under the first sentence of paragraph (4); and

“(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

“(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a MedicareAdvantage organization—

“(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period beginning on November 15, 2005, and ending on December 31, 2005, and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

“(B) may accept other changes to elections at such other times as the organization provides.

“(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

“(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D, except as the Secretary may provide (consistent with sections 1838 and 1860D–2) in order to prevent retroactive coverage.

“(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

“(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election

period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

“(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

“(g) GUARANTEED ISSUE AND RENEWAL.—

“(1) IN GENERAL.—Except as provided in this subsection, a MedicareAdvantage organization shall provide that at any time during which elections are accepted under this section with respect to a MedicareAdvantage plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

“(2) PRIORITY.—If the Secretary determines that a MedicareAdvantage organization, in relation to a MedicareAdvantage plan it offers, has a capacity limit and the number of MedicareAdvantage eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

“(A) first to such individuals as have elected the plan at the time of the determination; and

“(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

“(3) LIMITATION ON TERMINATION OF ELECTION.—

“(A) IN GENERAL.—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

“(B) BASIS FOR TERMINATION OF ELECTION.—A MedicareAdvantage organization may terminate an individual’s election under this section with respect to a MedicareAdvantage plan it offers if—

“(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

“(ii) the individual has engaged in disruptive behavior (as specified in such standards); or

“(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

“(C) CONSEQUENCE OF TERMINATION.—

“(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under the original medicare fee-for-service program option.

“(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicareAdvantage plan. Such an individual who fails to make an election dur-

ing such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option.

“(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857858., each MedicareAdvantage organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

“(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

“(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicareAdvantage organization to (or for the use of) MedicareAdvantage eligible individuals unless—

“(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review; and

“(B) the Secretary has not disapproved the distribution of such material or form.

“(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

“(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicareAdvantage plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

“(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicareAdvantage organization shall conform to fair marketing standards, in relation to MedicareAdvantage plans offered under this part, included in the standards established under section 1856. Such standards—

“(A) shall not permit a MedicareAdvantage organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

“(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

“(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

“(i) EFFECT OF ELECTION OF MEDICAREADVANTAGE PLAN OPTION.—

“(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable

under parts A, B, and D for items and services furnished to the individual.

“(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the MedicareAdvantage organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.”

SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.

Section 1852 (42 U.S.C. 1395w-22) is amended to read as follows:

“BENEFITS AND BENEFICIARY PROTECTIONS

“SEC. 1852. (a) BASIC BENEFITS.—

“(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each MedicareAdvantage plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

“(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan;

“(B) except as provided in paragraph (2)(D), qualified prescription drug coverage under part D to individuals residing in the area served by the plan;

“(C) a maximum limitation on out-of-pocket expenses and a unified deductible; and

“(D) additional benefits required under section 1854(d)(1).

“(2) SATISFACTION OF REQUIREMENT.—

“(A) IN GENERAL.—A MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

“(i) the sum of such payment amount and any cost-sharing provided for under the plan; is equal to at least

“(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

“(B) REFERENCE TO RELATED PROVISIONS.—For provisions relating to—

“(i) limitations on balance billing against MedicareAdvantage organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O); and

“(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(f).

“(C) ELECTION OF UNIFORM COVERAGE POLICY.—In the case of a MedicareAdvantage organization that offers a MedicareAdvantage plan in an area in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to MedicareAdvantage enrollees (as identified by the Secretary) apply with respect to all MedicareAdvantage enrollees enrolled in the plan.

“(D) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—

“(i) IN GENERAL.—A private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

“(ii) AVAILABILITY OF DRUG COVERAGE FOR ENROLLEES.—If a beneficiary enrolls in a plan making the election described in clause (i), the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

“(3) ENHANCED MEDICAL BENEFITS.—

“(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicareAdvantage organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), enhanced medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would substantially discourage enrollment by MedicareAdvantage eligible individuals with the organization.

“(B) AT ENROLLEES' OPTION.—A MedicareAdvantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

“(C) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a MedicareAdvantage private fee-for-service plan from offering enhanced medical benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

“(D) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

“(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicareAdvantage organization may (in the case of the provision of items and services to an individual under a MedicareAdvantage plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

“(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services; or

“(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

“(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicareAdvantage organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the benchmark amount announced under section 1853(b)(1)(A) at the beginning of such period, then, unless otherwise required by law—

“(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period; and

“(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional

circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period. The projection under the previous sentence shall be based on an analysis by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

“(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The Secretary shall have the authority to disapprove any MedicareAdvantage plan that the Secretary determines is designed to attract a population that is healthier than the average population residing in the service area of the plan.

“(7) UNIFIED DEDUCTIBLE DEFINED.—In this part, the term ‘unified deductible’ means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1813(b)(1) and the deductible under section 1833(b). Nothing in this part shall be construed as preventing a MedicareAdvantage organization from requiring coinsurance or a copayment for inpatient hospital services after the unified deductible is satisfied, subject to the limitation on enrollee liability under section 1854(f).

“(b) ANTIDISCRIMINATION.—

“(1) BENEFICIARIES.—

“(A) IN GENERAL.—A MedicareAdvantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

“(B) CONSTRUCTION.—Except as provided under section 1851(a)(3)(B), subparagraph (A) shall not be construed as requiring a MedicareAdvantage organization to enroll individuals who are determined to have end-stage renal disease.

“(2) PROVIDERS.—A MedicareAdvantage organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

“(c) DISCLOSURE REQUIREMENTS.—

“(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicareAdvantage organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicareAdvantage plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

“(A) SERVICE AREA.—The plan's service area.

“(B) BENEFITS.—Benefits offered under the plan, including information described section 1852(a)(1) (relating to benefits under the original Medicare fee-for-service program option, the maximum limitation in out-of-pocket expenses and the unified deductible, and qualified prescription drug coverage under part D, respectively) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicareAdvantage plans.

“(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and

any point-of-service option (including the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits for such option).

“(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

“(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

“(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

“(ii) the process and procedures of the plan for obtaining emergency services; and

“(iii) the locations of—

“(I) emergency departments; and

“(II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

“(F) ENHANCED MEDICAL BENEFITS.—Enhanced medical benefits available from the organization offering the plan, including—

“(i) whether the enhanced medical benefits are optional;

“(ii) the enhanced medical benefits covered; and

“(iii) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits.

“(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in non-payment.

“(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

“(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

“(2) DISCLOSURE UPON REQUEST.—Upon request of a MedicareAdvantage eligible individual, a MedicareAdvantage organization must provide the following information to such individual:

“(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

“(B) Information on procedures used by the organization to control utilization of services and expenditures.

“(C) Information on the number of grievances, reconsiderations, and appeals and on the disposition in the aggregate of such matters.

“(D) An overall summary description as to the method of compensation of participating physicians.

“(E) The information described in subparagraphs (A) through (C) in relation to the qualified prescription drug coverage provided by the organization.

“(d) ACCESS TO SERVICES.—

“(1) IN GENERAL.—A MedicareAdvantage organization offering a MedicareAdvantage plan may select the providers from whom the benefits under the plan are provided so long as—

“(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

“(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

“(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

“(i) the services were not emergency services (as defined in paragraph (3)), but—

“(I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

“(II) it was not reasonable given the circumstances to obtain the services through the organization;

“(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area; or

“(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

“(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

“(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

“(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicareAdvantage plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

“(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

“(A) IN GENERAL.—The term ‘emergency services’ means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

“(i) are furnished by a provider that is qualified to furnish such services under this title; and

“(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

“(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

“(ii) serious impairment to bodily functions; or

“(iii) serious dysfunction of any bodily organ or part.

“(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

“(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, B, or D for such services; or

“(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan,

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

“(e) QUALITY ASSURANCE PROGRAM.—

“(1) IN GENERAL.—Each MedicareAdvantage organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicareAdvantage plans of the organization.

“(2) ELEMENTS OF PROGRAM.—

“(A) IN GENERAL.—The quality assurance program of an organization with respect to a MedicareAdvantage plan (other than a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan) it offers shall—

“(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicareAdvantage plans and organizations;

“(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

“(iii) provide access to disease management and chronic care services;

“(iv) provide access to preventive benefits and information for enrollees on such benefits;

“(v) evaluate the continuity and coordination of care that enrollees receive;

“(vi) be evaluated on an ongoing basis as to its effectiveness;

“(vii) include measures of consumer satisfaction;

“(viii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

“(ix) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

“(x) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

“(xi) have mechanisms to detect both underutilization and overutilization of services;

“(xii) after identifying areas for improvement, establish or alter practice parameters;

“(xiii) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

“(xiv) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

“(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—The quality assurance program of an organization with respect to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan it offers shall—

“(i) meet the requirements of clauses (i) through (viii) of subparagraph (A);

“(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

“(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

“(C) DEFINITION OF NONNETWORK MSA PLAN.—In this subsection, the term ‘nonnetwork MSA plan’ means an MSA plan offered by a MedicareAdvantage organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

“(3) EXTERNAL REVIEW.—

“(A) IN GENERAL.—Each MedicareAdvantage organization shall, for each MedicareAdvantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (4)(B) and (14) of section 1154(a) with respect to services furnished by MedicareAdvantage plans for which payment is made under this title. The previous sentence shall not apply to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

“(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

“(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

“(4) TREATMENT OF ACCREDITATION.—

“(A) IN GENERAL.—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

“(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

“(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

“(ii) Subsection (b) (relating to anti-discrimination).

“(iii) Subsection (d) (relating to access to services).

“(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

“(v) Subsection (i) (relating to information on advance directives).

“(vi) Subsection (j) (relating to provider participation rules).

“(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

“(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate con-

tracts with MedicareAdvantage organizations under subsection (c)(2) of such section.

“(5) REPORT TO CONGRESS.—

“(A) IN GENERAL.—The Secretary shall submit to Congress a biennial report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

“(B) CONTENTS OF REPORT.—Each such report shall include the following:

“(i) A description of the means by which such programs focus on such racial and ethnic minorities.

“(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

“(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

“(f) GRIEVANCE MECHANISM.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicareAdvantage plans of the organization under this part.

“(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

“(1) DETERMINATIONS BY ORGANIZATION.—

“(A) IN GENERAL.—A MedicareAdvantage organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

“(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

“(2) RECONSIDERATIONS.—

“(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

“(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

“(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

“(A) RECEIPT OF REQUESTS.—

“(i) ENROLLEE REQUESTS.—An enrollee in a MedicareAdvantage plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the MedicareAdvantage organization.

“(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

“(B) ORGANIZATION PROCEDURES.—

“(i) IN GENERAL.—The MedicareAdvantage organization shall maintain procedures for expediting organization determinations and

reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

“(ii) EXPEDITATION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

“(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

“(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

“(5) APPEALS.—An enrollee with a MedicareAdvantage plan of a MedicareAdvantage organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

“(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a MedicareAdvantage organization maintains medical records or other health information regarding enrollees under this part, the MedicareAdvantage organization shall establish procedures—

“(1) to safeguard the privacy of any individually identifiable enrollee information;

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

“(3) to assure timely access of enrollees to such records and information.

“(i) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicareAdvantage organization shall meet the requirement of section

1866(f) (relating to maintaining written policies and procedures respecting advance directives).

“(j) RULES REGARDING PROVIDER PARTICIPATION.—

“(1) PROCEDURES.—Insofar as a MedicareAdvantage organization offers benefits under a MedicareAdvantage plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

“(A) providing notice of the rules regarding participation;

“(B) providing written notice of participation decisions that are adverse to physicians; and

“(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

“(2) CONSULTATION IN MEDICAL POLICIES.—A MedicareAdvantage organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization’s medical policy, quality, and medical management procedures.

“(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

“(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicareAdvantage organization (in relation to an individual enrolled under a MedicareAdvantage plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual’s condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

“(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicareAdvantage plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicareAdvantage organization offering the plan—

“(i) objects to the provision of such service on moral or religious grounds; and

“(ii) in the manner and through the written instrumentalities such MedicareAdvantage organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

“(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

“(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term ‘health care professional’ means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the MedicareAdvantage plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed pharmacist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified

nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

“(A) IN GENERAL.—No MedicareAdvantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

“(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

“(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

“(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group; and

“(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

“(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

“(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term ‘physician incentive plan’ means any compensation arrangement between a MedicareAdvantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

“(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicareAdvantage organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicareAdvantage plan of the organization under this part by the organization’s denial of medically necessary care.

“(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a MedicareAdvantage organization (with respect to an individual enrolled in a MedicareAdvantage private fee-for-service plan it offers), if—

“(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

“(B) before providing such services, the provider, professional, or other entity—

“(i) has been informed of the individual’s enrollment under the plan; and

“(ii) either—

“(I) has been informed of the terms and conditions of payment for such services under the plan; or

“(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the MedicareAdvantage organization.

“(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicareAdvantage organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicareAdvantage organization under this part) also applies with respect to an individual so enrolled.

“(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—

“(A) BALANCE BILLING LIMITS UNDER MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

“(i) IN GENERAL.—In the case of an individual enrolled in a MedicareAdvantage private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

“(ii) PROCEDURES TO ENFORCE LIMITS.—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

“(iii) ASSURING ENFORCEMENT.—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

“(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provisions—

“(i) establishing a minimum payment rate in the case of noncontract providers under a MedicareAdvantage private fee-for-service plan, see section 1852(a)(2); or

“(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

“(C) INFORMATION ON BENEFICIARY LIABILITY.—

“(i) IN GENERAL.—Each MedicareAdvantage organization that offers a MedicareAdvantage private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A, B, and D, and, if applicable, under Medicare supplemental policies) that includes a clear statement of the amount of the enrollee’s liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

“(i) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

“(I) notice of the fact that balance billing is permitted under such subparagraph for such services; and

“(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

“(1) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

“(1) ENSURING RETURN TO HOME SNF.—

“(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a MedicareAdvantage plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

“(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

“(ii) SNF AGREEMENT.—The facility has a contract with the MedicareAdvantage organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the MedicareAdvantage organization for the provision of such services and through which the enrollee would otherwise receive such services.

“(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

“(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the MedicareAdvantage plan.

“(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

“(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a MedicareAdvantage plan.

“(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

“(4) DEFINITIONS.—In this subsection:

“(A) HOME SKILLED NURSING FACILITY.—The term ‘home skilled nursing facility’ means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a MedicareAdvantage plan, any of the following skilled nursing facilities:

“(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

“(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided

residence to the enrollee at the time of such admission.

“(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

“(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term ‘continuing care retirement community’ means, with respect to an enrollee in a MedicareAdvantage plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.”.

SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS.

Section 1853 (42 U.S.C. 1395w-23) is amended to read as follows:

“PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

“SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

“(1) MONTHLY PAYMENTS.—

“(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each MedicareAdvantage organization, with respect to coverage of an individual for a month under this part in a MedicareAdvantage payment area, separate monthly payments with respect to—

“(i) benefits under the original medicare fee-for-service program under parts A and B in accordance with subsection (d); and

“(ii) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicareAdvantage organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicareAdvantage plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicareAdvantage payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

“(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

“(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

“(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the pe-

riod beginning on the date on which the individual enrolls with a MedicareAdvantage organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

“(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

“(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the MedicareAdvantage organization for each individual enrolled with the organization shall equal the MedicareAdvantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

“(i) by multiplying the benchmark amount for that payment area by the ratio of—

“(I) the payment amount determined under subsection (d)(4); to

“(II) the weighted service area benchmark amount determined under subsection (d)(2); and

“(ii) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

“(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

“(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of payments to plans under subsection (d)(4)(B).

“(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to MedicareAdvantage plans offered by MedicareAdvantage organizations in 2005, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

“(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

“(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

“(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

“(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the greater of the following amounts (adjusted as appropriate for the application of the risk adjustment methodology under paragraph (3)):

“(A) MINIMUM AMOUNT.— $\frac{1}{2}$ of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year.

“(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).

“(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘local fee-for-service rate’ means the amount of payment for a month in a MedicareAdvantage payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive benefits under the original Medicare fee-for-service program option and not enrolled in a MedicareAdvantage plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876.

“(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

“(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

“(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

“(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates are payable during the year—

“(aa) for the indirect costs of medical education under section 1886(d)(5)(B); and

“(bb) for direct graduate medical education costs under section 1886(h).

“(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

“(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

“(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D-11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

“(A) The benchmark amount for each MedicareAdvantage payment area (as calculated under subsection (a)(4)) for the year.

“(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each MedicareAdvantage payment area for the year.

“(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

“(A) provide for notice to MedicareAdvantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

“(B) provide such organizations with an opportunity to comment on such proposed changes.

“(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in

methodology used in the announcement in sufficient detail so that MedicareAdvantage organizations can compute each payment factor described in paragraph (1).

“(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

“(1) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a MedicareAdvantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

“(A) BLENDED CAPITATION RATE.—The sum of—

“(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the MedicareAdvantage payment area, as determined under paragraph (3) for the year; and

“(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

“(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

“(1) For 1998, \$367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

“(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

“(iii) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, \$525, and for any other area \$475.

“(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (i) for such area for 2000.

“(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)) of the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

“(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

“(C) MINIMUM PERCENTAGE INCREASE.—

“(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

“(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

“(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

“(A) for 1998, the ‘area-specific percentage’ is 90 percent and the ‘national percentage’ is 10 percent;

“(B) for 1999, the ‘area-specific percentage’ is 82 percent and the ‘national percentage’ is 18 percent;

“(C) for 2000, the ‘area-specific percentage’ is 74 percent and the ‘national percentage’ is 26 percent;

“(D) for 2001, the ‘area-specific percentage’ is 66 percent and the ‘national percentage’ is 34 percent;

“(E) for 2002, the ‘area-specific percentage’ is 58 percent and the ‘national percentage’ is 42 percent; and

“(F) for a year after 2002, the ‘area-specific percentage’ is 50 percent and the ‘national percentage’ is 50 percent.

“(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

“(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

“(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

“(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

“(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

“(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

“(I) 1998 is 20 percent;

“(II) 1999 is 40 percent;

“(III) 2000 is 60 percent;

“(IV) 2001 is 80 percent; and

“(V) a succeeding year is 100 percent.

“(C) PAYMENT ADJUSTMENT.—

“(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

“(I) for the indirect costs of medical education under section 1886(d)(5)(B); and

“(II) for direct graduate medical education costs under section 1886(h).

“(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

“(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for

1997 a rate that is more representative of the costs of the enrollees in the area.

“(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of Medicare services (as classified by the Secretary), of the product (for each such type of service) of—

“(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year;

“(ii) the proportion of such rate for the year which is attributable to such type of services; and

“(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

“(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the ‘national standardized annual Medicare+Choice capitation rate’ for a year is equal to—

“(i) the sum (for all Medicare+Choice payment areas) of the product of—

“(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3); and

“(II) the average number of Medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

“(ii) the sum of the products described in clause (i)(II) for all areas for that year.

“(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

“(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

“(A) IN GENERAL.—In this part, the ‘national per capita Medicare+Choice growth percentage’ for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

“(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

“(i) for 1998, 0.8 percentage points;

“(ii) for 1999, 0.5 percentage points;

“(iii) for 2000, 0.5 percentage points;

“(iv) for 2001, 0.5 percentage points;

“(v) for 2002, 0.3 percentage points; and

“(vi) for a year after 2002, 0 percentage points.

“(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before

computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

“(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—

“(A) IN GENERAL.—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

“(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

“(d) SECRETARY’S DETERMINATION OF PAYMENT AMOUNT.—

“(1) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under section 1854(a) for the coverage of benefits under the original Medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii).

“(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for the benefits under the original Medicare fee-for-service program option for each plan equal to the weighted average of the benchmark amounts for benefits under such original Medicare fee-for-service program option for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii).

“(3) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the weighted service area benchmark amount (as determined under paragraph (2)) for purposes of determining—

“(A) the payment amount under paragraph (4); and

“(B) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

“(4) DETERMINATION OF PAYMENT AMOUNT FOR ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the payment amount for MedicareAdvantage plans for the benefits under the original Medicare fee-for-service program option as follows:

“(i) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount.

“(ii) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

“(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary

shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

“(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Secretary of the actuarial costs associated with the new benefits.

“(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes of this part, the term ‘benefits under the original Medicare fee-for-service program option’ means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to, or enrolled for, benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

“(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

“(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term ‘MedicareAdvantage payment area’ means a county, or equivalent area specified by the Secretary.

“(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicareAdvantage payment area shall be a State or such other payment area as the Secretary specifies.

“(3) GEOGRAPHIC ADJUSTMENT.—

“(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 2005) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a MedicareAdvantage payment area in the State otherwise determined under paragraph (1)—

“(i) to a single statewide MedicareAdvantage payment area;

“(ii) to the metropolitan based system described in subparagraph (C); or

“(iii) to consolidating into a single MedicareAdvantage payment area non-contiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

“(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for MedicareAdvantage payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicareAdvantage payment areas in the State in the absence of the adjustment under this paragraph.

“(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

“(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area,

all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicareAdvantage payment area; and

“(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicareAdvantage payment area.

“(D) AREAS.—In subparagraph (C), the terms ‘metropolitan statistical area’, ‘consolidated metropolitan statistical area’, and ‘primary metropolitan statistical area’ mean any area designated as such by the Secretary of Commerce.

“(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

“(1) IN GENERAL.—If the amount of the MedicareAdvantage monthly MSA premium (as defined in section 1854(b)(2)(D)) for an MSA plan for a year is less than $\frac{1}{2}$ of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicareAdvantage MSA established (and, if applicable, designated) by the individual under paragraph (2).

“(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

“(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicareAdvantage MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986); and

“(B) if the individual has established more than 1 such MedicareAdvantage MSA, has designated 1 of such accounts as the individual’s MedicareAdvantage MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

“(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicareAdvantage MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

“(g) PAYMENTS FROM TRUST FUNDS.—Except as provided in section 1858A(c) (relating to payments for qualified prescription drug coverage), the payment to a MedicareAdvantage organization under this section for individuals enrolled under this part with the organization and payments to a MedicareAdvantage MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments other-

wise payable under this section for October 2006 shall be paid on the first business day of October 2006.

“(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual’s—

“(1) election under this part of a MedicareAdvantage plan offered by a MedicareAdvantage organization—

“(A) payment for such services until the date of the individual’s discharge shall be made under this title through the MedicareAdvantage plan or the original Medicare fee-for-service program option (as the case may be) elected before the election with such organization,

“(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual’s discharge; and

“(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

“(2) termination of election with respect to a MedicareAdvantage organization under this part—

“(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual’s discharge;

“(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicareAdvantage organization; and

“(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

“(i) SPECIAL RULE FOR HOSPICE CARE.—

“(1) INFORMATION.—A contract under this part shall require the MedicareAdvantage organization to inform each individual enrolled under this part with a MedicareAdvantage plan offered by the organization about the availability of hospice care if—

“(A) a hospice program participating under this title is located within the organization’s service area; or

“(B) it is common practice to refer patients to hospice programs outside such service area.

“(2) PAYMENT.—If an individual who is enrolled with a MedicareAdvantage organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

“(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

“(B) payment for other services for which the individual is eligible notwithstanding the individual’s election of hospice care under section 1812(d)(1), including services not related to the individual’s terminal illness, shall be made by the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

“(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).”.

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

“SUBMISSION OF BIDS; PREMIUMS

“SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

“(1) IN GENERAL.—Not later than the second Monday in September and except as pro-

vided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

“(A) notice of such intent and information on the service area of the plan;

“(B) the plan type for each plan;

“(C) if the MedicareAdvantage plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

“(D) the enrollment capacity (if any) in relation to the plan and each payment area;

“(E) the expected mix, by health status, of enrolled individuals; and

“(F) such other information as the Secretary may specify.

“(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a MedicareAdvantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

“(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original Medicare fee-for-service program option as follows:

“(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under the original Medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

“(ii) For the enhanced medical benefits package offered—

“(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

“(II) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirement for additional benefits under subsection (g);

“(III) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (as defined in subsection (b)(2)(C));

“(IV) a description of any cost-sharing;

“(V) a description of whether the amount of the unified deductible has been lowered or the maximum limitations on out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid);

“(VI) such other information as the Secretary considers necessary.

“(iii) The assumptions that the MedicareAdvantage organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

“(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

“(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid under subparagraph (A)(i) a MedicareAdvantage plan offered by a MedicareAdvantage organization satisfies subparagraphs (A) and (C) of section 1852(a)(1) if the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled

in such plan under this part with respect to benefits under the original medicare fee-for-service program option on which that bid is based (ignoring any reduction in cost-sharing offered by such plan as enhanced medical benefits under paragraph (2)(A)(ii) or required under clause (ii) or (iii) of subsection (g)(1)(C)) equals the amount specified in subsection (f)(1)(B).

“(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted.

“(4) REVIEW.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the MedicareAdvantage organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

“(B) MSA EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).

“(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the bid if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of MedicareAdvantage eligible individuals.

“(5) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOING.—Each bid amount submitted under paragraph (1) for a MedicareAdvantage plan must reasonably and equitably reflect the cost of benefits provided under that plan.

“(b) MONTHLY PREMIUMS CHARGED.—

“(1) IN GENERAL.—

“(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization shall be equal to the sum of the following:

“(i) The MedicareAdvantage monthly basic beneficiary premium (if any).

“(ii) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (if any).

“(iii) The MedicareAdvantage monthly obligation for qualified prescription drug coverage (if any).

“(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

“(2) PREMIUM TERMINOLOGY.—For purposes of this part:

“(A) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term ‘MedicareAdvantage monthly basic beneficiary premium’ means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (d)(2) for the plan.

“(B) MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term ‘MedicareAdvantage monthly beneficiary ob-

ligation for qualified prescription drug coverage’ means, with respect to a MedicareAdvantage plan, the amount determined under section 1858A(d).

“(C) MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The term ‘MedicareAdvantage monthly beneficiary premium for enhanced medical benefits’ means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

“(D) MEDICAREADVANTAGE MONTHLY MSA PREMIUM.—The term ‘MedicareAdvantage monthly MSA premium’ means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

“(c) UNIFORM PREMIUM.—The MedicareAdvantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan.

“(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

“(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall require the plan to provide additional benefits in accordance with subsection (g).

“(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).

“(e) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate election of individuals for a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(1)(C)(i)).

“(f) LIMITATION ON ENROLLEE LIABILITY.—

“(1) FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—The sum of—

“(A) the MedicareAdvantage monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (determined on the same basis as used in determining the plan’s bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A); must equal

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive benefits under the original medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the

year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

“(2) FOR ENHANCED MEDICAL BENEFITS.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to enhanced medical benefits relating to benefits under the original medicare fee-for-service program option, the sum of the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year minus the actuarial value of any additional benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(2)(i)(II).

“(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or in the United States, eligible to enroll in the MedicareAdvantage plan involved under this part or on the basis of other appropriate data.

“(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

“(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1852(a)(1); exceed

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if they were not members of a MedicareAdvantage organization for the year.

“(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

“(1) REQUIREMENT.—

“(A) IN GENERAL.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may specify in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D)).

“(B) EXCESS AMOUNT.—For purposes of this paragraph, the term ‘excess amount’ means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount (determined under section 1853(d)(2)) exceeds the plan bid (as adjusted under section 1853(d)(1)).

“(C) ADDITIONAL BENEFITS DESCRIBED.—The additional benefits described in this subparagraph are as follows:

“(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

“(ii) Lowering the amount of the unified deductible and decreasing the maximum limitations on out-of-pocket expenses for individuals enrolled in the plan.

“(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

“(iv) Subject to subparagraph (E), such additional benefits as the organization may specify.

“(v) Contributing to the stabilization fund under paragraph (2).

“(vi) Any combination of the reductions and benefits described in clauses (i) through (v).

“(D) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the term ‘adjusted excess amount’ means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

“(E) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

“(F) PREMIUM REDUCTIONS.—

“(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may elect a reduction in its payments under section 1853(a)(1)(A)(i) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

“(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a MedicareAdvantage plan—

“(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

“(II) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

“(G) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

“(H) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such enhanced medical benefits.

“(2) STABILIZATION FUND.—A MedicareAdvantage organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicareAdvantage plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such Trust Funds.

“(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term ‘adjusted community rate’ for a service or services means, at the election of a MedicareAdvantage organization, either—

“(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this part if the rate of payment were determined

under a ‘community rating system’ (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)); or

“(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicareAdvantage coverage, or MedicareAdvantage eligible individuals in the area, in the State, or in the United States, eligible to elect MedicareAdvantage coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

“(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine the average amount of payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

“(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to MedicareAdvantage organizations under section 1853.

“(i) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a MedicareAdvantage organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of 1 or more MedicareAdvantage payment areas.”

(b) STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS.

Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

“SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

“SEC. 1858A. (a) AVAILABILITY.—

“(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), on and after January 1,

2006, a MedicareAdvantage organization offering a MedicareAdvantage plan (except for an MSA plan) shall make available qualified prescription drug coverage that meets the requirements for such coverage under this part and part D to each enrollee of the plan.

“(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE.—Pursuant to section 1852(a)(2)(D), a private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

“(2) REFERENCE TO PROVISION PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—For the provisions of part D, made applicable to this part pursuant to paragraph (1), that permit a plan to make available qualified prescription drug coverage that includes coverage of covered drugs that exceeds the coverage required under paragraph (1) of section 1860D–6 in an area, but only if the MedicareAdvantage organization offering the plan also offers a MedicareAdvantage plan in the area that only provides the coverage that is required under such paragraph (1), see paragraph (2) of such section.

“(3) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Pursuant to sections 1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage may not make available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

“(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a MedicareAdvantage organization under a MedicareAdvantage plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, and such other requirements under part D that the Secretary determines appropriate in the same manner as such requirements apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or the plan under this part.

“(c) PAYMENTS FOR PRESCRIPTION DRUGS.—“(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—For each year (beginning with 2006), the Secretary shall pay to each MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

“(B) APPLICATION OF PART D RISK CORRIDOR, STABILIZATION RESERVE FUND, AND ADMINISTRATIVE EXPENSES PROVISIONS.—The provisions of subsections (b), (c), and (d) of section 1860D–16 shall apply to a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage and payments made to such organization under subparagraph (A) in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan and payments made to such entity under subsection (a) of section 1860D–16.

“(2) PAYMENT FROM PRESCRIPTION DRUG ACCOUNT.—Payment made to MedicareAdvantage organizations under this subsection shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

“(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a MedicareAdvantage eligible individual receiving qualified prescription drug coverage under a MedicareAdvantage plan during a year after 2005, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage of such individual in the year shall be determined in the same manner as the monthly beneficiary obligation is determined under section 1860D-17 for eligible beneficiaries enrolled in a Medicare Prescription Drug plan, except that, for purposes of this subparagraph, any reference to the monthly plan premium approved by the Secretary under section 1860D-13 shall be treated as a reference to the monthly premium for qualified prescription drug coverage submitted by the MedicareAdvantage organization offering the plan under section 1854(a)(2)(A) and approved by the Secretary.

“(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D-18, including subsection (b) of such section, shall apply to the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage (as determined under subsection (d)) required to be paid by a MedicareAdvantage eligible individual enrolled in a MedicareAdvantage plan in the same manner as such provisions apply to the amount of the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan under part D.

“(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND REINSURANCE PAYMENTS.—For provisions—

“(1) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D-19; and

“(2) providing a MedicareAdvantage organization with reinsurance payments for certain expenses incurred in providing qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D-20.”

(b) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking “section 1854(f)(1)(E)” and inserting “section 1854(d)(1)(A)(i)”.

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

Section 1858(h) (as added by section 211) is amended by inserting “(including subsection (i) of such section)” after “section 1857”.

SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE CHOICES.

On and after January 1, 2006, the MedicareAdvantage program under part C of title XVIII of the Social Security Act shall be administered by the Center for Medicare Choices established under section 1808 such title (as added by section 301), and each reference to the Secretary made in such part shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGA-

NIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w-25) is amended—

(1) in subsection (b), in the matter preceding paragraph (1), by inserting “subparagraphs (A), (B), and (D) of” before “section 1852(A)(1)”;

(2) by striking “Medicare+Choice” and inserting “MedicareAdvantage” each place it appears.

(b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856 (42 U.S.C. 1395w-26) is amended by striking “Medicare+Choice” and inserting “MedicareAdvantage” each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.—Section 1857 (42 U.S.C. 1395w-27) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking “amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums” and inserting “amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits”;

(B) in subparagraph (F), by striking “or” after the semicolon at the end;

(C) in subparagraph (G), by adding “or” after the semicolon at the end; and

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

“(H)(i) charges any individual an amount in excess of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage under section 1858(A)(d);

“(ii) provides coverage for prescription drugs that is not qualified prescription drug coverage;

“(iii) offers prescription drug coverage, but does not make standard prescription drug coverage available; or

“(iv) provides coverage for prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option described in section 1851(a)(1)(A)(i)) as an enhanced medical benefit under section 1852(a)(3)(D) or as an additional benefit under section 1854(g)(1)(F);” and

(2) by striking “Medicare+Choice” and inserting “MedicareAdvantage” each place it appears.

(d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section 1859 (42 U.S.C. 1395w-28) is amended—

(1) by striking subsection (c) and inserting the following new subsection:

“(c) OTHER REFERENCES TO OTHER TERMS.—

“(1) ENHANCED MEDICAL BENEFITS.—The term ‘enhanced medical benefits’ is defined in section 1852(a)(3)(E).

“(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—The term ‘MedicareAdvantage eligible individual’ is defined in section 1851(a)(3).

“(3) MEDICAREADVANTAGE PAYMENT AREA.—The term ‘MedicareAdvantage payment area’ is defined in section 1853(d).

“(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The ‘national per capita Medicare+Choice growth percentage’ is defined in section 1853(c)(6).

“(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms ‘MedicareAdvantage monthly basic beneficiary premium’, ‘MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage’, and ‘MedicareAdvantage monthly beneficiary premium for enhanced medical benefits’ are defined in section 1854(b)(2).

“(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term ‘qualified prescription

drug coverage’ has the meaning given such term in section 1860D(9).

“(7) STANDARD PRESCRIPTION DRUG COVERAGE.—The term ‘standard prescription drug coverage’ has the meaning given such term in section 1860D(10).”; and

(2) by striking “Medicare+Choice” and inserting “MedicareAdvantage” each place it appears.

(e) CONFORMING AMENDMENTS EFFECTIVE BEFORE 2006.—

(1) EXTENSION OF MSAs.—Section 1851(b)(4) (42 U.S.C. 1395w-21(b)(4)) is amended by striking “January 1, 2003” and inserting “January 1, 2004”.

(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w-21(e)) is amended—

(A) in paragraph (2)(A), by striking “THROUGH 2004” and “December 31, 2004” and inserting “THROUGH 2005” and “December 31, 2005”, respectively;

(B) in the heading of paragraph (2)(B), by striking “DURING 2005” and inserting “DURING 2006”;

(C) in paragraphs (2)(B)(i) and (2)(C)(i), by striking “2005” and inserting “2006” each place it appears;

(D) in paragraph (2)(D), by striking “2004” and inserting “2005”; and

(E) in paragraph (4), by striking “2005” and inserting “2006” each place it appears.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act.

(e) OTHER CONFORMING AMENDMENTS.—

(1) CONFORMING MEDICARE CROSS-REFERENCES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking “section 1854(f)(1)(E)” and inserting “section 1854(g)(1)(C)(i)”.

(B) Section 1840(i) (42 U.S.C. 1395s(i)) is amended by striking “section 1854(f)(1)(E)” and inserting “section 1854(g)(1)(C)(i)”.

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by striking “section 1854(f)(1)(E)” and inserting “section 1854(g)(1)(C)(i)”.

(D) Section 1876(k)(3)(A) (42 U.S.C. 1395mm(k)(3)(A)) is amended by inserting “(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)” after section 1853(a).

(F) Section 1876(k)(4) (42 U.S.C. 1395mm(k)(4)(A)) is amended—

(i) in subparagraph (A), by striking “section 1853(a)(3)(B)” and inserting “section 1853(a)(3)(D)”;

(ii) in subparagraph (B), by striking “section 1854(g)” and inserting “section 1854(h)”.

(G) Section 1876(k)(4)(C) (42 U.S.C. 1395mm(k)(4)(C)) is amended by inserting “(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)” after “section 1851(e)(6)”.

(H) Section 1894(d) (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

“(3) APPLICATION OF PROVISIONS.—For purposes of paragraphs (1) and (2), the references to section 1853 and subsection (a)(2) of such section in such paragraphs shall be deemed to be references to those provisions as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003.”

(2) CONFORMING MEDICARE TERMINOLOGY.—Title XVIII (42 U.S.C. 1395 et seq.), except for part C of such title (42 U.S.C. 1395w-21 et seq.), and title XIX (42 U.S.C. 1396 et seq.) are each amended by striking “Medicare+Choice” and inserting “MedicareAdvantage” each place it appears.

SEC. 209. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 208(d)(3) and subsection (b), the amendments made by this title shall apply with respect to plan years beginning on and after January 1, 2006.

(b) **MEDICARE ADVANTAGE MSA PLANS.**—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w-21(a)(2)(B)) as if this title had not been enacted.

Subtitle B—Preferred Provider Organizations**SEC. 211. ESTABLISHMENT OF MEDICARE ADVANTAGE PREFERRED PROVIDER PROGRAM OPTION.**

(a) **ESTABLISHMENT OF PREFERRED PROVIDER PROGRAM OPTION.**—Section 1851(a)(2) is amended by adding at the end the following new subparagraph:

“(D) **PREFERRED PROVIDER ORGANIZATION PLANS.**—A Medicare Advantage preferred provider organization plan under the program established under section 1858.”

(b) **PROGRAM SPECIFICATIONS.**—Part C of title XVIII (42 U.S.C. 1395w-21 et seq.) is amended by inserting after section 1857 the following new section:

“PREFERRED PROVIDER ORGANIZATIONS

“**SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.—**

“(1) **IN GENERAL.**—Beginning on January 1, 2006, there is established a preferred provider program under which preferred provider organization plans offered by preferred provider organizations are offered to Medicare Advantage eligible individuals in preferred provider regions.

“(2) **DEFINITIONS.**—

“(A) **PREFERRED PROVIDER ORGANIZATION.**—The term ‘preferred provider organization’ means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to preferred provider organizations.

“(B) **PREFERRED PROVIDER ORGANIZATION PLAN.**—The term ‘preferred provider organization plan’ means a Medicare Advantage plan that—

“(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

“(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

“(iii) is offered by a preferred provider organization.

“(C) **PREFERRED PROVIDER REGION.**—The term ‘preferred provider region’ means—

“(i) a region established under paragraph (3); and

“(ii) a region that consists of the entire United States.

“(3) **PREFERRED PROVIDER REGIONS.**—For purposes of this part the Secretary shall establish preferred provider regions as follows:

“(A) There shall be at least 10 regions.

“(B) Each region must include at least 1 State.

“(C) The Secretary may not divide States so that portions of the State are in different regions.

“(D) To the extent possible, the Secretary shall include multistate metropolitan statistical areas in a single region. The Secretary may divide metropolitan statistical areas where it is necessary to establish regions of such size and geography as to maximize the participation of preferred provider organization plans.

“(E) The Secretary may conform the preferred provider regions to the service areas established under section 1860D-10.

“(b) **ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.**—

“(1) **IN GENERAL.**—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organization plans offered by a preferred provider organization.

“(2) **SERVICE AREA.**—The service area of a preferred provider organization plan shall be a preferred provider region.

“(3) **AVAILABILITY.**—Each preferred provider organization plan must be offered to each Medicare Advantage eligible individual who resides in the service area of the plan.

“(4) **AUTHORITY TO PROHIBIT RISK SELECTION.**—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

“(5) **ASSURING ACCESS TO SERVICES IN PREFERRED PROVIDER ORGANIZATION PLANS.**—

“(A) **IN GENERAL.**—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

“(B) **DETERMINATION OF SUFFICIENT ACCESS.**—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

“(C) **CONSTRUCTION.**—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

“(c) **PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS.**—

“(1) **PAYMENTS TO ORGANIZATIONS.**—

“(A) **MONTHLY PAYMENTS.**—

“(i) **IN GENERAL.**—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

“(I) benefits under the original Medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

“(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

“(ii) **SPECIAL RULE FOR END-STAGE RENAL DISEASE.**—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

“(B) **ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.**—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

“(C) **COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.**—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

“(D) **ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.**—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

“(2) **ANNUAL CALCULATION OF BENCHMARK AMOUNTS FOR PREFERRED PROVIDER REGIONS.**—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to coverage of the benefits available under the original Medicare fee-for-service program option equal to the average of each benchmark amount calculated under section 1853(a)(4) for each Medicare Advantage payment area for the year within such region, weighted by the number of Medicare Advantage eligible individuals residing in each such payment area for the year.

“(3) **ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.**—

“(A) **ANNUAL ANNOUNCEMENT.**—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D-11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

“(i) The benchmark amount for each preferred provider region (as calculated under paragraph (2)(A)) for the year.

“(ii) The factors to be used for adjusting payments described under—

“(I) the comprehensive risk adjustment methodology described in paragraph (1)(C) with respect to each preferred provider region for the year; and

“(II) the methodology used for adjustment for geographic variations within such region established under paragraph (1)(D).

“(B) **ADVANCE NOTICE OF METHODOLOGICAL CHANGES.**—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall—

“(i) provide for notice to preferred provider organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

“(ii) provide such organizations with an opportunity to comment on such proposed changes.

“(C) **EXPLANATION OF ASSUMPTIONS.**—In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that preferred provider organizations can compute each payment factor described in such subparagraph.

“(4) **SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.**—The Secretary shall determine the payment amount for plans as follows:

“(A) **REVIEW OF PLAN BIDS.**—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original Medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

“(B) **DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.**—The Secretary shall calculate a preferred provider regional benchmark amount for that plan for the benefits under the original Medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used

with respect to numbers of enrolled individuals.

“(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

“(i) the payment amount under subparagraph (D); and

“(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

“(D) DETERMINATION OF PAYMENT AMOUNT.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a preferred provider organization for a preferred provider organization plan as follows:

“(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

“(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

“(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph (3)(A)(ii).

“(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR PREFERRED PROVIDER ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

“(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to preferred provider organizations in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

“(5) PAYMENTS FROM TRUST FUND.—The payment to a preferred provider organization under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

“(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect to preferred provider organizations.

“(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to preferred provider organizations.

“(d) SUBMISSION OF BIDS BY PPOS; PREMIUMS.—

“(1) SUBMISSION OF BIDS BY PREFERRED PROVIDER ORGANIZATIONS.—

“(A) IN GENERAL.—For the requirements on submissions by MedicareAdvantage preferred provider organization plans, see section 1854(a)(1).

“(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a pre-

ferred provider organization plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

“(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

“(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

“(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN A REGION.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

“(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan offered by a preferred provider organization shall be equal to the sum of the following:

“(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

“(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

“(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

“(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

“(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

“(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

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

“(A) IN GENERAL.—For 2007 and 2008, the preferred provider organization offering a preferred provider organization plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original Medicare fee-for-service program for all enrollees under the plan in the previous year.

“(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

“(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

“(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

“(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a preferred provider organization plan may not exceed an amount determined appropriate by the Administrator.

“(2) ADJUSTMENT OF PAYMENT.—

“(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

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

“(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

“(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

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

“(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

“(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

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

“(3) ESTABLISHMENT OF RISK CORRIDORS.—

“(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to a range as follows:

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

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

“(II) an amount equal to 5 percent of such target amount.

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

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

“(II) an amount equal to 10 percent of such target amount.

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

“(I) such target amount; and

“(II) the amount described in clause (i)(II).
 “(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

“(I) such target amount; and
 “(II) the amount described in clause (ii)(II).

“(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a preferred provider organization plan offered by a preferred provider organization in a year, an amount equal to the sum of—

“(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

“(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

“(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A preferred provider organization that offers a preferred provider organization plan that provides enhanced medical benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

“(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

“(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a preferred provider organization and a preferred provider organization plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

“(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred provider organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a preferred provider organization plan.

“(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to preferred provider organizations.

“(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.”

(c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—Section 1859(a) is amended by adding at the end the following new paragraph:

“(3) PREFERRED PROVIDER ORGANIZATION; PREFERRED PROVIDER ORGANIZATION PLAN; PREFERRED PROVIDER REGION.—The terms ‘preferred provider organization’, ‘preferred provider organization plan’, and ‘preferred provider region’ have the meaning given such terms in section 1858(a)(2).”

Subtitle C—Other Managed Care Reforms

SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.

(a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking “2004” and inserting “2009”.

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

“(5) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Prescription Drug and Medicare Improvements Act of 2003 for plan years beginning on or after January 1, 2004, shall provide that the following provisions of the Medicare+Choice program under part C (and, on and after January 1, 2006, the provisions of the MedicareAdvantage program under such part) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare+Choice organizations and Medicare+Choice plans (or, on and after January 1, 2006, MedicareAdvantage organizations and MedicareAdvantage plans, respectively) under such part:

“(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

“(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

“(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

“(D) Section 1854(g), or, on and after January 1, 2006, section 1854(h) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

“(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

“(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits and, on and after January 1, 2006, enhanced medical benefits under the plan subject to the approval of the Secretary).

“(G) The provisions of part C relating to timelines for benefit filings, contract renewal, and beneficiary notification.

“(H) Section 1854(e), or, on and after January 1, 2006, section 1854(f) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).”

(c) PERMITTING DEDICATED GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDICARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated and amended by subsections (a) and (b), is amended—

(1) in subparagraph (A), by striking “After the date of the enactment” and inserting “Except as provided in subparagraph (C), after the date of the enactment”;

(2) in subparagraph (B), by striking “subparagraph (C)” and inserting “subparagraph (D)”;

(3) by redesignating subparagraph (C) as subparagraph (D); and

(4) by inserting after subparagraph (B), the following new subparagraph:

“(C) Subject to paragraph (5) and subparagraph (D), the Secretary shall approve an application to enter into a reasonable cost contract under this section if—

“(i) the application is submitted to the Secretary by a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act) that, as of January 1, 2004, and except as provided in section 1301(b)(3)(B) of such Act, provides at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups), as defined in section 1302(4) of such Act; and

“(ii) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section.”

SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: “Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.”

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–28(b)) is amended by adding at the end the following new paragraph:

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

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

“(B) SPECIAL NEEDS BENEFICIARY.—The term ‘special needs beneficiary’ means a Medicare+Choice eligible individual who—

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

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

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

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

“(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2008, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.”

(d) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the Medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking “part C or” and inserting “part C, with a PACE provider under section 1894 or 1934, or”;

(B) by striking “(i)”;

(C) by striking “and (ii)”;

(D) by striking “members of the organization” and inserting “members of the organization or PACE program eligible individuals enrolled with the PACE provider.”.

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

“(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

“(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

“(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

“(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).”.

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended— (A) in paragraph (64), by striking “and” at the end;

(B) in paragraph (65), by striking the period at the end and inserting “; and”; and

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

“(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).”.

(2) REFERENCE IN MEDICAID STATUTE.—Section 1934(b) (42 U.S.C. 1396u-4(b)) is amended by adding at the end the following new paragraphs:

“(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

“(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under title

XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

“(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

“(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the “Institute”) shall conduct an evaluation of leading health care performance measures and options to implement policies that align performance with payment under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the Medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b-6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary of Health and Human Services, the Committees on Ways and Means and Energy

and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance in the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare+Choice program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c-3(a)(1)) is amended by inserting “, Medicare+Choice organizations and MedicareAdvantage organizations under part C, and prescription drug card sponsors and eligible entities under part D” after “under section 1876”.

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

“(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, prescription drug card sponsors and eligible entities under part D, and Medicare+Choice and MedicareAdvantage plans under part C quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

“ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

“SEC. 1808. (a) ESTABLISHMENT.—By not later than March 1, 2004, the Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

“(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

“(1) ADMINISTRATOR.—

“(A) IN GENERAL.—The Center for Medicare Choices shall be headed by an Administrator (in this section referred to as the ‘Administrator’) who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

“(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

“(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator’s term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

“(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Choices, and shall have authority and control over all personnel and activities thereof.

“(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Center for Medicare Choices. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

“(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Center for Medicare Choices as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

“(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Center for Medicare Choices as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

“(2) DEPUTY ADMINISTRATOR.—

“(A) IN GENERAL.—There shall be a Deputy Administrator of the Center for Medicare Choices who shall be appointed by the Administrator.

“(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

“(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

“(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be the Acting Administrator of the Center for Medicare Choices during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

“(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

“(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

“(1) DUTIES.—

“(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

“(i) negotiating, entering into, and enforcing, contracts with plans for the offering of MedicareAdvantage plans under part C, including the offering of qualified prescription drug coverage under such plans; and

“(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the offering of Medicare Prescription Drug plans under part D.

“(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including duties relating to—

“(i) reasonable cost contracts with eligible organizations under section 1876(h); and

“(ii) demonstration projects carried out in part or in whole under such parts, including the demonstration project carried out through a MedicareAdvantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs

“(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

“(2) MANAGEMENT STAFF.—

“(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

“(i) The review, negotiation, and administration of health care contracts.

“(ii) The design of health care benefit plans.

“(iii) Actuarial sciences.

“(iv) Compliance with health plan contracts.

“(v) Consumer education and decision making.

“(B) COMPENSATION.—

“(i) IN GENERAL.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

“(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

“(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

“(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

“(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

“(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

“(d) OFFICE OF BENEFICIARY ASSISTANCE.—

“(1) ESTABLISHMENT.—The Secretary shall establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

“(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

“(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

“(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

“(ii) Benefits, and limitations on payment under parts A, and B, including information on medicare supplemental policies under section 1882.

“(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, and D, and medicare supplemental policies with benefits under MedicareAdvantage plans under part C.

“(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

“(3) MEDICARE OMBUDSMAN.—

“(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

“(B) DUTIES.—The Medicare Ombudsman shall—

“(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

“(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

“(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MedicareAdvantage organization, an eligible entity under part D, or the Secretary; and

“(II) assistance to such beneficiaries with any problems arising from disenrollment from a MedicareAdvantage plan under part C or a prescription drug plan under part D; and

“(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

“(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

“(i) provide information about the medicare program; and

“(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

“(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

“(1) ESTABLISHMENT.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the ‘Board’). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

“(2) REPORTS.—

“(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

“(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

“(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

“(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

“(iii) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

“(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

“(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

“(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

“(3) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

“(4) MEMBERSHIP.—

“(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the

Board shall consist of 7 members to be appointed as follows:

“(i) Three members shall be appointed by the President.

“(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

“(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

“(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

“(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

“(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

“(6) TERMS OF OFFICE.—

“(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

“(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

“(i) one shall be appointed for a term of 1 year;

“(ii) three shall be appointed for terms of 2 years; and

“(iii) three shall be appointed for terms of 3 years.

“(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

“(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

“(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

“(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

“(9) DIRECTOR AND STAFF.—

“(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

“(B) IN GENERAL.—With the approval of the Board, the Director may appoint such additional personnel as the Director considers appropriate.

“(C) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

“(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

“(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and

from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.”.

(b) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by adding at the end the following: “By not later than 1 year after the date of the enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.”.

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking “shall serve as the Secretary” and inserting “and the Administrator of the Center for Medicare Choices shall serve as the Co-Secretaries”.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

“Administrator of the Centers for Medicare & Medicaid Services.”.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking “Administrator of the Health Care Financing Administration.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

(1) by striking “(iv) For discharges” and inserting “(iv)(I) Subject to the succeeding provisions of this clause, for discharges”; and

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

“(II) For discharges occurring during the last 3 quarters of fiscal year 2004, the operating standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the operating standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

“(III) For discharges occurring in a fiscal year beginning with fiscal year 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under

subsection (b)(3)(B)(i) for the fiscal year involved.”.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking “IN DIFFERENT AREAS”;

(B) in the matter preceding clause (i), by striking “each of which is”;

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2005,” before “for hospitals”; and

(ii) in subclause (II), by striking “and” after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2005,” before “for hospitals”; and

(ii) in subclause (II), by striking the period at the end and inserting “; and”; and

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

“(iii) for a fiscal year beginning after fiscal year 2004, for hospitals located in all areas, to the product of—

“(I) the applicable operating standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.”.

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

(A) in the matter preceding subparagraph (A), by inserting “, for fiscal years before fiscal year 1997,” before “a regional adjusted DRG prospective payment rate”; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate for each region.”.

SEC. 402. ADJUSTMENT TO THE MEDICARE PATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

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

(1) by striking “WAGE LEVELS.—The Secretary” and inserting “WAGE LEVELS.—

“(i) IN GENERAL.—Except as provided in clause (ii), the Secretary”; and

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

“(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—

“(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2004, the Secretary shall substitute ‘62 percent’ for the proportion described in the first sentence of clause (i).

“(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.”.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: “The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.”.

SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

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

“(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

“(A) PAYMENT ADJUSTMENT.—

“(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

“(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

“(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

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

“(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

“(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term ‘low-volume hospital’ means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

“(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

“(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

“(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).”.

SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting “, and, after October 1, 2004, for any other hospital described in clause (iv),” after “clause (iv)(I)” in the matter preceding subclause (I).

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

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting “and before October 1, 2004,” after “April 1, 2001,”; and

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

(ii) in subclause (III)—

(I) by inserting “and before October 1, 2004,” after “April 1, 2001,”; and

(II) by inserting “or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)” after “clause (xii)”;

(iii) in subclause (IV)—

(I) by inserting “and before October 1, 2004,” after “April 1, 2001,”; and

(II) by inserting “or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)” after “clause (x) or (xi)”;

(iv) in subclause (V)—

(I) by inserting “and before October 1, 2004,” after “April 1, 2001,”; and

(II) by inserting “or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)” after “clause (xi)”;

(v) in subclause (VI)—

(I) by inserting “and before October 1, 2004,” after “April 1, 2001,”; and

(II) by inserting “or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)” after “clause (x)”;

(B) in clause (viii), by striking “The formula” and inserting “For discharges occurring before October 1, 2004, the formula”; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking “For purposes” and inserting “With respect to discharges occurring before October 1, 2004, for purposes”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2004.

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i-4(c)(2)(B)(iii)) is amended to read as follows:

“(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;”.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i-4(f)) is amended by striking “and the number of beds used at any time for acute care inpatient services does not exceed 15 beds”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2004.

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

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(1)(8) (42 U.S.C. 1395m(1)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A-482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2005.

(2) TECHNICAL CORRECTION.—Section 1834(1) (42 U.S.C. 1395m(1)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A-486), as paragraph (9).

(c) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

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

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to costs incurred for services provided on or after January 1, 2005.

(d) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—

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

(A) in subparagraph (C), by striking "and" after the semicolon at the end;

(B) in subparagraph (D), by adding "and" after the semicolon at the end; and

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

"(E) inpatient critical access hospital services;"

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for inpatient critical access facility services furnished on or after January 1, 2005.

(e) EXCLUSION OF NEW CAHS FROM PPS HOSPITAL WAGE INDEX CALCULATION.—Section 1886(d)(3)(E)(i) (42 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is amended by inserting after the first sentence the following new sentence: "In calculating the hospital wage levels under the preceding sentence applicable with respect to cost reporting periods beginning on or after January 1, 2004, the Secretary shall exclude the wage levels of any facility that became a critical access hospital prior to the cost reporting period for which such hospital wage levels are calculated."

(f) PROVISIONS RELATED TO CERTAIN RURAL HOSPITALS.—

(1) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—Section 1820(g) (42 U.S.C. 1395i-4(g)) is amended—

(A) by redesignating paragraph (3)(F) as paragraph (5) and redesignating and indenting appropriately; and

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

"(4) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—

"(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

"(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

"(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed \$50,000.

"(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance."

(2) AUTHORIZATION FOR APPROPRIATIONS.—Section 1820(j) (42 U.S.C. 1395i-4(j)) is amended to read as follows:

"(j) AUTHORIZATION OF APPROPRIATIONS.—

"(1) HI TRUST FUND.—There are authorized to be appropriated from the Federal Hospital

Insurance Trust Fund for making grants to all States under—

"(A) subsection (g), \$25,000,000 in each of the fiscal years 1998 through 2002; and

"(B) paragraphs (1) and (2) of subsection (g), \$40,000,000 in each of the fiscal years 2004 through 2008.

"(2) GENERAL REVENUES.—There are authorized to be appropriated from amounts in the Treasury not otherwise appropriated for making grants to all States under subsection (g)(4), \$25,000,000 in each of the fiscal years 2004 through 2008."

(3) REQUIREMENT THAT STATES AWARDED GRANTS CONSULT WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE SUCH GRANTS.—

(A) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i-4(g)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

"(6) REQUIRED CONSULTATION FOR STATES AWARDED GRANTS.—A State awarded a grant under paragraph (1) or (2) shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant."

(B) EFFECTIVE DATE AND APPLICATION.—The amendment made by subparagraph (A) shall take effect on the date of enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(I) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive."

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after October 1, 2004.

SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1812(d)(2)(A) (42 U.S.C. 1395d(d)(2)(A)) in the matter following clause (i)(II), is amended—

(1) by inserting "or services described in section 1861(s)(2)(K)" after "except that clause (i) shall not apply to physicians' services"; and

(2) by inserting ", or by a physician assistant, nurse practitioner, or clinical nurse specialist whom is not an employee of the hospice program, and who the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care," after the "if not an employee of the hospice program)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to hospice care furnished on or after October 1, 2004.

SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS UNDER MEDICARE.

Effective for cost reporting periods beginning on or after October 1, 2004, for purposes of payments to hospitals under the Medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include professional educational training programs, recognized by the Secretary, for psychologists.

SEC. 409. REVISION OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

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

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before October 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) on or after October 1, 2004, and before October 1, 2009, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent; and

"(iv) on or after October 1, 2009, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent."

SEC. 410. AUTHORITY REGARDING GERIATRIC FELLOWSHIPS.

The Secretary shall have the authority to clarify that geriatric training programs are eligible for 2 years of fellowship support for purposes of making payments for direct graduate medical education under subsection (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) and indirect medical education under subsection (d)(5)(B) of such section on or after October 1, 2004.

SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONPROVIDER SETTING AND A TECHNICAL AMENDMENT REGARDING THE 3-YEAR ROLLING AVERAGE AND THE IME RATIO.

(a) CLARIFICATION OF REQUIREMENTS FOR COUNTING RESIDENTS TRAINING IN NONPROVIDER SETTING.—

(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties."

(2) IME.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties."

(b) LIMITING ONE-YEAR LAG IN THE INDIRECT MEDICAL EDUCATION (IME) RATIO AND THREE-YEAR ROLLING AVERAGE IN RESIDENT COUNT FOR IME AND FOR DIRECT GRADUATE MEDICAL EDUCATION (D-GME) TO MEDICAL RESIDENCY PROGRAMS.—

(1) IME RATIO AND IME ROLLING AVERAGE.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: "For cost reporting periods beginning during fiscal years beginning on or after October 1, 2004, subclauses (I) and (II) shall be applied only with respect to a hospital's approved medical residency training programs in the fields of allopathic and osteopathic medicine."

(2) D-GME ROLLING AVERAGE.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

"(iv) APPLICATION FOR FISCAL YEAR 2004 AND SUBSEQUENT YEARS.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2004, clauses (i) through (iii) shall be applied only with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine."

SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking "and" at the end;

(2) in subparagraph (S), by striking the period and inserting ", and"; and

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

"(T) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care—

"(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

"(ii) under a program funded by the Indian Health Service and operated by an urban In-

dian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services)."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(2) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) REPORT.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w-4(e)(1)) is amended—

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

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

"(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

"(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

"(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

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

"(II) 1.000 for services furnished during 2005, 2006, and 2007.

"(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) PROCEDURES FOR SECRETARY, AND NOT PHYSICIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE MADE.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

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

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

"(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1)."

(b) EDUCATIONAL PROGRAM REGARDING THE MEDICARE INCENTIVE PAYMENT PROGRAM.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)).

(c) ONGOING GAO STUDY AND ANNUAL REPORT ON THE MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) ANNUAL REPORTS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Comptroller General considers appropriate.

SEC. 423. INCREASE IN RENAL DIALYSIS COMPOSITE RATE.

Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2005 and 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395rr(b)(7)), as added by section 433(b)(5).

SEC. 424. EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) SMALL RURAL HOSPITALS.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by inserting "and during 2006" after "2004,".

(b) SOLE COMMUNITY HOSPITALS.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by adding at the end the following:

"(iii) TEMPORARY TREATMENT FOR SOLE COMMUNITY HOSPITALS.—In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished in 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference."

SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) INCREASE.—

(1) IN GENERAL.—In the case of an applicable covered OPD service (as defined in paragraph (2)) that is furnished by a hospital described in clause (i) or (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395f(t)), as amended by section 424, on or after January 1, 2005, and before January 1, 2008, the Secretary shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) APPLICABLE COVERED OPD SERVICES DEFINED.—For purposes of this section, the term “applicable covered OPD service” means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395f(t))) established under paragraph (2)(B) of such section.

(b) NO EFFECT ON COPAYMENT AMOUNT.—The Secretary shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395f(t)(8)(A)) as if this section had not been enacted.

(c) NO EFFECT ON INCREASE UNDER HOLD HARMLESS OR OUTLIER PROVISIONS.—The Secretary shall apply the temporary hold harmless provision under clause (i) and (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395f(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) WAIVING BUDGET NEUTRALITY AND NO REVISION OR ADJUSTMENTS.—The Secretary shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395f(t)(9)) because of the application of subsection (a)(1).

(e) NO EFFECT ON PAYMENTS AFTER INCREASE PERIOD ENDS.—The Secretary shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395f(t))) under such section that are furnished after January 1, 2008.

(f) TECHNICAL AMENDMENT.—Section 1833(t)(2)(B) (42 U.S.C. 1395f(t)(2)(B)) is amended by inserting “(and periodically revise such groups pursuant to paragraph (9)(A))” after “establish groups”.

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.

Section 1834(1) (42 U.S.C. 1395m(1)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

“(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.—

“(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2005, and before January 1, 2008, for which the transportation originates in a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent.

“(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.”.

SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) COVERAGE.—Section 1834(1) (42 U.S.C. 1395m(1)), as amended by section 426, is amended by adding at the end the following new paragraph:

“(11) ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES.—

“(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

“(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

“(ii) complies with equipment and crew requirements established by the Secretary.

“(B) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A) if such service is requested—

“(i) by a physician or a hospital in accordance with the physician’s or hospital’s responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

“(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

“(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that the patient’s condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

“(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

“(C) AIR AMBULANCE SERVICES DEFINED.—For purposes of this paragraph, the term ‘air ambulance service’ means fixed wing and rotary wing air ambulance services.”.

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting “, subject to section 1834(1)(11),” after “but”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2005.

SEC. 428. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395f) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2005 or 2006 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

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

SEC. 429. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1833(f) (42 U.S.C. 1395f(f)) is amended—

(1) in paragraph (1), by striking “, and” at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking “in a subsequent year” and inserting “in 1989 through 2004”; and

(B) by striking the period at the end and inserting a semicolon; and

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

“(3) in 2005, at \$80 per visit; and

“(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.”.

SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking “clauses (ii) and (iii)” and inserting “clauses (ii), (iii), and (iv)”; and

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

“(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

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

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

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

(b) CERTAIN SERVICES FURNISHED BY AN ENTITY JOINTLY OWNED BY HOSPITALS AND CRITICAL ACCESS HOSPITALS.—For purposes of applying section 411.15(p)–(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) TECHNICAL AMENDMENTS.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking “section 1888(e)(2)(A)(ii)” and inserting “clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)”.

(d) EFFECTIVE DATE.—The amendments made by this section and the provision of subsection (b) shall apply to services furnished on or after January 1, 2005.

SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT AND CERTAIN ORTHOTICS; ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DME PROVIDERS.

(a) FREEZE FOR DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (E), by striking “and” at the end;

(2) in subparagraph (F)—

(A) by striking “a subsequent year” and inserting “2003”; and

(B) by striking “the previous year.” and inserting “2002;”;

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

“(G) for each of the years 2004 through 2010—

“(i) in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

“(ii) in the case of covered items not described in clause (i), 0 percentage points; and

“(H) for a subsequent year, the percentage increase described in subparagraph (B) for the year involved.”.

(b) **FREEZE FOR OFF-THE-SHELF ORTHOTICS.**—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) in clause (vii), by striking “and” at the end;

(2) in clause (viii), by striking “a subsequent year” and inserting “2003”; and

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

“(ix) for each of the years 2004 through 2010—

“(I) in the case of orthotics that have not been custom-fabricated, 0 percent; and

“(II) in the case of prosthetics, prosthetic devices, and custom-fabricated orthotics, the percentage increase described in clause (viii) for the year involved; and

“(x) for 2011 and each subsequent year, the percentage increase described in clause (viii) for the year involved;”.

(c) **ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT PROVIDERS.**—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(1) by redesignating paragraph (17), as added by section 451(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), as paragraph (19); and

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

“(20) **IDENTIFICATION OF QUALITY STANDARDS.**—

“(A) **IN GENERAL.**—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for providers of durable medical equipment throughout the United States that are developed by recognized independent accreditation organizations (as designated under subparagraph (B)(i)) and with which such providers shall be required to comply in order to—

“(i) participate in the program under this title;

“(ii) furnish any item or service described in subparagraph (D) for which payment is made under this part; and

“(iii) receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service described in subparagraph (D) for which payment may be made under this title.

“(B) **DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.**—

“(i) **IN GENERAL.**—Not later than the date that is 6 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall designate independent accreditation organizations for purposes of subparagraph (A).

“(ii) **CONSULTATION.**—In determining which independent accreditation organizations to designate under clause (i), the Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, suppliers, and manufacturers to review (and advise the Secretary concerning) selection of accrediting organizations and the quality standards of such organizations.

“(C) **QUALITY STANDARDS.**—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

“(D) **ITEMS AND SERVICES DESCRIBED.**—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection, other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

“(E) **PHASED-IN IMPLEMENTATION.**—The application of the quality standards described in subparagraph (A) shall be phased-in over a period that does not exceed 3 years.”.

SEC. 432. APPLICATION OF COINSURANCE AND DEDUCTIBLE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) **COINSURANCE.**—

(1) **IN GENERAL.**—Section 1833(a) (42 U.S.C. 1395f(a)) is amended—

(A) in paragraph (1)(D)(i), by striking “(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)”;

(B) in paragraph (2)(D)(i), by striking “(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866)”.

(2) **CONFORMING AMENDMENT.**—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking “and with respect to clinical diagnostic laboratory tests for which payment is made under part B”.

(b) **DEDUCTIBLE.**—Section 1833(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 433. BASING MEDICARE PAYMENTS FOR COVERED OUTPATIENT DRUGS ON MARKET PRICES.

(a) **MEDICARE MARKET BASED PAYMENT AMOUNT.**—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking “equal to 95 percent of the average wholesale price.” and inserting “equal to—

“(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

“(B) in the case of a drug or biological furnished on or after January 1, 2004, the payment amount specified in—

“(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

“(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5).”;

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

“(4)(A) Subject to subparagraph (C), the payment amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

“(i) the average wholesale price for the drug or biological; or

“(ii) the amount determined under subparagraph (B)

“(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

“(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

“(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

“(ii) In the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological.

“(C)(i) The Secretary shall establish a process under which the Secretary deter-

mines, for such drugs or biologicals as the Secretary determines appropriate, whether the widely available market price to physicians or suppliers for the drug or biological furnished in a year is different from the payment amount established under subparagraph (B) for the year. Such determination shall be based on the information described in clause (ii) as the Secretary determines appropriate.

“(ii) The information described in this clause is the following information:

“(I) Any report on drug or biological market prices by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States that is made available after December 31, 1999.

“(II) A review of drug or biological market prices by the Secretary, which may include information on such market prices from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers, or any other source the Secretary determines appropriate.

“(III) Data and information submitted by the manufacturer of the drug or biological or by another entity.

“(IV) Other data and information as determined appropriate by the Secretary.

“(iii) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for a year, the following provisions shall apply:

“(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii)(I) for the year and all subsequent years.

“(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

“(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under this subparagraph shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(II) for the year involved.

“(iv) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the payment amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the payment amount in such previous year until the payment amount is equal to the amount determined under clause (i), as increased each year by the percentage increase described in subparagraph (B)(i)(II) for the year. The preceding sentence shall not apply to a drug or biological where a generic version of the drug or biological first enters the market on or after January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological).

“(5) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply:

“(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a time, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological in the market during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

“(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a time, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians or suppliers for the drug or biological in the year.

“(C) The amount specified in this paragraph for a drug or biological for the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (A) and other information that the Secretary determines appropriate.

“(D) The amount specified in this paragraph for a drug or biological for the year after the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

“(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

“(i) the average wholesale price for the drug or biological; or

“(ii) the amount determined—

“(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the year, if such paragraph was applied by substituting ‘the payment determined under paragraph (5)(E)(ii)(II) for the year’ for ‘established under subparagraph (B) for the year’; and

“(II) if no determination described in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.”

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMINISTRATION OF DRUGS AND BIOLOGICALS.—

(1) ADJUSTMENT IN PHYSICIAN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w-4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking “The adjustments” and inserting “Subject to clause (iv), the adjustments”; and

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

“(iv) EXEMPTION FROM BUDGET NEUTRALITY IN 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004.”; and

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

“(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR DRUG ADMINISTRATION SERVICES FOR 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey sub-

mitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

“(i) covers practice expenses for oncology administration services; and

“(ii) meets criteria established by the Secretary for acceptance of such surveys.”

(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for the administration of more than 1 anticancer chemotherapeutic agent to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy if the Secretary determines such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments to such Act made by paragraph (1).

(4) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

“(6)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2004, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled ‘Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost’ (GAO-03-184), provide for a separate payment for the administration of such blood clotting factors in an amount that the Secretary determines to be appropriate.

“(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2004, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraphs (4) and (5) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

“(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2005 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.”

(5) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b) (42 U.S.C. 1395rr(b)) is amended—

(A) in paragraph (7), by adding at the end the following new sentence: “In the case of dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12).”; and

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

“(12)(A) In the case of dialysis services furnished during 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

“(i) the sum of the total amount of—

“(I) the composite rate payments for such services for the year, as increased under this paragraph; and

“(II) the payments for drugs and biologicals (other than erythropoetin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1842(o) for the year; is equal to

“(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(II) that would have been made if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

“(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased pursuant to section 423 of the Prescription Drug and Medicare Improvement Act of 2003.

“(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent.

“(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 or a subsequent year, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year (determined as if such section 423 had not been enacted), increased by 0.05 percent.

“(E) If the Secretary implements a reduction in the payment amount under paragraph (4)(C) or (5) for a drug or biological described in subparagraph (A)(i)(II) for a year after 2004, the Secretary shall, as estimated by the Secretary—

“(i) increase the composite rate for dialysis services furnished in such year in the same manner that the composite rate for such services for 2004 was increased under subparagraph (A); and

“(ii) increase the percentage increase under subparagraph (C) or (D) (as applicable) for years after the year described in clause (i) to ensure that such increased percentage would result in expenditures equal to the sum of the total composite rate payments for such services for such years and the total payments for drugs and biologicals described in subparagraph (A)(i)(II) is equal to the sum of the total amount of the composite rate

payments under this paragraph for such years and the payments for the drugs and biologicals described in subparagraph (A)(i)(II) that would have been made if the reduction in payment amount described in subparagraph had not been made.

“(F) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.”

(6) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

“(7)(A) Subject to subparagraph (B), in the case of infusion drugs and biologicals furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may make separate payments for furnishing such drugs and biologicals in an amount determined by the Secretary if the Secretary determines such separate payment to be appropriate.

“(B) In determining the amount of any separate payment under subparagraph (A) for a year, the Secretary shall ensure that the total amount of payments under this part for such infusion drugs and biologicals for the year and such separate payments for the year does not exceed the total amount of payments that would have been made under this part for the year for such infusion drugs and biologicals if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.”

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

“(8)(A) Subject to subparagraph (B), in the case of inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may increase payments for such equipment under section 1834(a) and may make separate payments for furnishing such drugs and biologicals if the Secretary determines such increased or separate payments are necessary to appropriately furnish such equipment and drugs and biologicals to beneficiaries.

“(B) The total amount of any increased payments and separate payments under subparagraph (A) for a year may not exceed an amount equal to 10 percent of the amount (as estimated by the Secretary) by which—

“(i) the total amount of payments that would have been made for such drugs and biologicals for the year if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted; excepted

“(ii) the total amount of payments for such drugs and biologicals under paragraphs (4) and (5).”

(8) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended to read as follows:

“(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary—

“(A) in the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

“(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the

Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.”

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) and (7), is amended by adding at the end the following new paragraph:

“(9)(A) Subject to subparagraph (B), the Secretary may increase (in an amount determined appropriate) the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

“(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such year (as estimated by the Secretary).”

(c) LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendments made by subsection (a) unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of drug or biological for which the Secretary is required to make an adjustment, as specified in the amendments made by, and provisions of, subsection (b).

(d) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), (7), and (9) of subsection (b), is amended by adding at the end the following new paragraph:

“(10) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraph (2) or paragraphs (4) through (9).”

(2) PHYSICIAN FEE SCHEDULE.—Section 1848(i)(1) (42 U.S.C. 1395w-4(i)(1)) is amended—

(A) in subparagraph (D), by striking “and” at the end;

(B) in subparagraph (E), by striking the period at the end and inserting “, and”; and

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

“(F) adjustments in practice expense relative value units under subsection (c)(2)(H).”

(3) MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON BENEFICIARY ACCESS TO DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) REPORT.—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subparagraph (A) together with such recommendations as the Comptroller General determines to be appropriate.

(2) STUDY AND REPORT BY THE HHS INSPECTOR GENERAL ON MARKET PRICES OF DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct 1 or more studies that—

(i) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers; and

(ii) compare such widely available market prices to the payment amount for such drugs and biologicals under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o)).

(B) REQUIREMENT.—In conducting the study under subparagraph (A), the Inspector General shall focus on those drugs and biologicals that represent the largest portions of expenditures under the medicare program for drugs and biologicals.

(C) REPORT.—The Inspector General shall prepare a report on any study conducted under subparagraph (A).

SEC. 434. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395f(b)) is amended by striking “and \$100 for 1991 and subsequent years” and inserting the following: “, \$100 for 1991 through 2005, \$125 for 2006, and for 2007 and thereafter, the amount in effect for the previous year, increase by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar”.

SEC. 435. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: “(ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if under such arrangement such entity submits the bill for such service and such arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate.”

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking “except to an employer or facility as described in clause (A)” and inserting “except to an employer or entity as described in subparagraph (A)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after the date of enactment of this Act.

SEC. 436. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A–551) is amended by inserting “, and for services furnished during 2005” before the period at the end.

SEC. 437. ADEQUATE REIMBURSEMENT FOR OUTPATIENT PHARMACY THERAPY UNDER THE HOSPITAL OUTPATIENT PPS.

(a) SPECIAL RULES FOR DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

“(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

“(A) BEFORE 2007.—

“(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2005, and before January 1, 2007, hospitals shall be reimbursed as follows:

“(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF A CURRENT OPD SERVICE.—The amount of payment for a drug or biological described in subparagraph (D) provided as a part of a service that was a covered OPD service on May 1, 2003, shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under section 1842(o) on such date.

“(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price that would have been determined under section 1842(o) on May 1, 2003, if payment for such a drug or biological could have been made under this part on that date.

“(ii) UPDATE FOR 2006.—For 2006, the amounts determined under clauses (i) and (ii) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

“(B) AFTER 2007.—

“(i) ONGOING STUDY AND REPORTS ON ADEQUATE REIMBURSEMENTS.—

“(I) STUDY.—The Secretary shall contract with an eligible organization (as defined in subclause (IV)) to conduct a study to determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D).

“(II) STUDY REQUIREMENTS.—The study conducted under subclause (I) shall—

“(aa) be accurate to within 3 percent of true mean hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level;

“(bb) begin not later than January 1, 2005; and

“(cc) be updated annually for changes in hospital costs and the addition of newly marketed products.

“(III) REPORTS.—Not later than January 1 of each year (beginning with 2006), the Secretary shall submit to Congress a report on the study conducted under clause (i) together with recommendations for such legislative or administrative action as the Secretary determines to be appropriate.

“(IV) ELIGIBLE ORGANIZATION DEFINED.—In this clause, the term ‘eligible organization’ means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

“(ii) ESTABLISHMENT OF PAYMENT METHODOLOGY.—Notwithstanding paragraph (6), the Secretary, in establishing a payment methodology on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, shall take into consideration the findings of the study conducted under clause (i)(I) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

“(C) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term ‘applicable percentage’ means—

“(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(iv)), or an orphan product designated under section 526 of the Food, Drug, and Cosmetic Act to which the

prospective payment system established under this subsection did not apply under the final rule for 2003 payments under such system, 94 percent;

“(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 91 percent; and

“(iii) with respect to a noninnovator multiple source drug (as defined in section 1927(k)(7)(A)(iii)), 71 percent.

“(D) DRUGS AND BIOLOGICALS DESCRIBED.—A drug or biological described in this paragraph is any drug or biological—

“(i) for which the amount of payment was determined under paragraph (6) prior to January 1, 2005;

“(ii) which is assigned to a drug specific ambulatory payment classification on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003; and

“(iii) that would have been reimbursed under paragraph (6) but for the application of this paragraph.”.

(b) EXCEPTIONS TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: “In determining the budget neutrality adjustment required by the preceding sentence for fiscal years 2005 and 2006, the Secretary shall not take into account any expenditures that would not have been made but for the application of paragraph (13).”.

SEC. 438. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

“(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

“(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

“(ii) APPLICATION.—Paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003 unless—

“(I) such application was being made to such drug or biological prior to such date of enactment; and

“(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

“(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary’s authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.

SEC. 439. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.

(a) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part

405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) EFFECTIVE DATE.—This section shall apply to clinical trials begun on or after January 1, 2005.

SEC. 440. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: “No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2002, 2003, 2004, or 2005 and who demonstrates to the Secretary before December 31, 2005, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2005. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2005 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin 1 year after the date of the enactment of this Act and shall end on December 31, 2005.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 441. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term “chiropractic services” has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term “demonstration project” means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term “eligible beneficiary” means an individual who is enrolled under part B of the Medicare program.

(4) MEDICARE PROGRAM.—The term “Medicare program” means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a Medicare Advantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 6 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

- (i) 3 shall be in rural areas; and
- (ii) 3 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 3 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 442. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

“HEALTH CARE QUALITY DEMONSTRATION PROGRAM

“SEC. 1866C. (a) DEFINITIONS.—In this section:

“(1) BENEFICIARY.—The term ‘beneficiary’ means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the Medicare Advantage program) under part C.

“(2) HEALTH CARE GROUP.—

“(A) IN GENERAL.—The term ‘health care group’ means—

“(i) a group of physicians that is organized at least in part for the purpose of providing physician’s services under this title;

“(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

“(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

“(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

“(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term ‘physician’ means any individual who furnishes services that may be paid for as physicians’ services under this title.

“(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

“(1) the provision of incentives to improve the safety of care provided to beneficiaries;

“(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

“(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

“(4) encourage shared decision making between providers and patients;

“(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

“(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

“(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

“(c) ADMINISTRATION BY CONTRACT.—

“(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

“(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

“(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

“(B) streamline documentation and reporting requirements otherwise required under this title.

“(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program under parts A and B or the package of benefits available through a staff model or a dedicated group model health maintenance organization under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient’s surrogate) on the basis of the patient’s age or expected length of life or of the patient’s present or predicted disability, degree of medical dependency, or quality of life.

“(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

“(1) be a health care group;

“(2) meet quality standards established by the Secretary, including—

“(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

“(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

“(C) encouraging patient participation in preference-based decisions;

“(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

“(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering

the incentives of health care delivery and changing the allocation of resources; and

“(3) meet such other requirements as the Secretary may establish.

“(e) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

“(f) **BUDGET NEUTRALITY.**—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

“(g) **NOTICE REQUIREMENTS.**—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

“(h) **PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.**—In carrying out the demonstration program under this section, the Secretary may direct—

“(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

“(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

“(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

“(i) **IMPLEMENTATION.**—The Secretary shall not implement the demonstration program before October 1, 2004.”

SEC. 443. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) **SITES.**—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

(3) **DURATION.**—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) **IMPLEMENTATION.**—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) **PARTICIPANTS.**—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if

such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) **PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.**—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) **COMPLEX CLINICAL CARE MANAGEMENT FEE.**—

(1) **PAYMENT.**—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) **DEVELOPMENT OF FEE.**—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) **FUNDING.**—

(1) **IN GENERAL.**—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) **BUDGET NEUTRALITY.**—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) **REPORT.**—Not later than 6 months after the completion of the demonstration pro-

gram under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) **DEFINITIONS.**—In this section:

(1) **ACTIVITY OF DAILY LIVING.**—The term “activity of daily living” means eating, toiling, transferring, bathing, dressing, and continence.

(2) **CHRONIC CONDITION.**—The term “chronic condition” means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which there is a need for ongoing medical care, and which may affect an individual’s ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) **ELIGIBLE BENEFICIARY.**—The term “eligible beneficiary” means any individual who—

(A) is enrolled for benefits under part B of the medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) **INSTRUMENTAL ACTIVITY OF DAILY LIVING.**—The term “instrumental activity of daily living” means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

(5) **MEDICARE PROGRAM.**—The term “medicare program” means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) **PRINCIPAL CARE PHYSICIAN.**—The term “principal care physician” means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 444. MEDICARE FEE-FOR-SERVICE CARE COORDINATION DEMONSTRATION PROGRAM.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) **SITES.**—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(3) **DURATION.**—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) **IMPLEMENTATION.**—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) **PARTICIPANTS.**—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) **CONTRACTS WITH CMOS.**—

(1) IN GENERAL.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) CANCELLATION.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) NUMBER OF CMOS.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) PAYMENT TO CMOS.—

(1) PAYMENT.—Under a contract entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(2) PORTION OF PAYMENT AT RISK.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization the portion of the fee described in paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the agreed upon savings and outcomes targets for the year.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(2) WAIVER OF MEDIGAP PREEMPTIONS.—The Secretary shall waive any provision of section 1882 of the Social Security Act that would prevent an insurance carrier described in subsection (h)(3)(D) from participating in the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT SERVICES.—The term “care management services” means services that are furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the Secretary that are consistent with guidelines established by the American Geriatrics Society.

(2) ELIGIBLE BENEFICIARY.—The term “eligible beneficiary” means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under

part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) CARE MANAGEMENT ORGANIZATION.—The term “care management organization” means an organization that meets such qualifications as the Secretary may specify and includes any of the following:

(A) A physician group practice, hospital, home health agency, or hospice program.

(B) A disease management organization.

(C) A Medicare+Choice or MedicareAdvantage organization.

(D) Insurance carriers offering Medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(E) Such other entity as the Secretary determines to be appropriate.

SEC. 445. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component;

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under subparagraphs (E) and (F) of section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)), as added by section 421, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(A) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(B) the mobility of physicians, including specialists, over the last decade; and

(6) an evaluation of appropriateness of extending such adjustment or making such adjustment permanent.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

Subtitle C—Provisions Relating to Parts A and B

SEC. 451. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE ADJUSTMENT FACTORS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is amended—

(1) by striking “FACTORS.—The Secretary” and inserting “FACTORS.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary”; and

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

“(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2005 and 2006, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more than 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.”

SEC. 453. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking “and” at the end of subparagraph (A); and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

“(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and”.

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

“(7) SPECIALTY HOSPITAL.—

“(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term ‘specialty hospital’ means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

“(i) patients with a cardiac condition;

“(ii) patients with an orthopedic condition;

“(iii) patients receiving a surgical procedure; or

“(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

“(B) EXCEPTION.—For purposes of this section, the term ‘specialty hospital’ does not include any hospital—

“(i) determined by the Secretary—
“(I) to be in operation before June 12, 2003;
or
“(II) under development as of such date;
“(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and
“(iii) that meets such other requirements as the Secretary may specify.”.

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

“(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

“(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

“(B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and

“(C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.”.

(b) EFFECTIVE DATE.—Subject to paragraph (2), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the “demonstration program”) under which the Secretary provides eligible medicare beneficiaries with coverage under the medicare program of substitute adult day services furnished by an adult day services facility.

(b) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—

(1) PAYMENT RATE.—For purposes of making payments to an adult day services facility for substitute adult day services under the demonstration program, the following rules shall apply:

(A) ESTIMATION OF PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for all home health services described in subsection (i)(4)(B)(i) under the plan of care.

(B) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under subparagraph (A).

(2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full for substitute adult day services (including those services described in clauses (ii) through (iv) of subsection (i)(4)(B)) furnished by the facility to an eligible medicare beneficiary the amount of payment provided under the demonstration program for home

health services consisting of substitute adult services.

(3) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration program and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration program and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration program had not been conducted, the Secretary shall adjust the rate of payment to adult day services facilities under paragraph (1)(B) in order to eliminate such excess.

(c) DEMONSTRATION PROGRAM SITES.—The demonstration program shall be conducted in not more than 3 sites selected by the Secretary.

(d) DURATION; IMPLEMENTATION.—

(1) DURATION.—The Secretary shall conduct the demonstration program for a period of 3 years.

(2) IMPLEMENTATION.—The Secretary may not implement the demonstration program before October 1, 2004.

(e) VOLUNTARY PARTICIPATION.—Participation of eligible medicare beneficiaries in the demonstration program shall be voluntary.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program.

(2) MAY NOT WAIVE ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES.—The Secretary may not waive the beneficiary eligibility requirements for home health services under title XVIII of the Social Security Act.

(g) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration program.

(2) REPORT.—Not later than 30 months after the commencement of the demonstration program, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the eligible medicare beneficiaries participating in the demonstration program as compared to such outcomes and costs to such beneficiaries receiving only home health services under title XVIII of the Social Security Act for the same health conditions.

(B) Such recommendations regarding the extension, expansion, or termination of the program as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) ADULT DAY SERVICES FACILITY.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the term “adult day services facility” means a public agency or private organization, or a subdivision of such an agency or organization, that—

(i) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) INCLUSION.—Notwithstanding subparagraph (A), the term “adult day services facility” shall include a home health agency in which the items and services described in

clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURETY BOND.—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) ELIGIBLE MEDICARE BENEFICIARY.—The term “eligible medicare beneficiary” means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term “home health agency” has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term “substitute adult day services” means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to promote physical and mental health and furnished to the individual by the adult day services facility in a group setting for a period of not fewer than 4 and not greater than 12 hours per day.

(iv) A medication management program (as defined in subparagraph (C)).

(C) MEDICATION MANAGEMENT PROGRAM.—For purposes of subparagraph (B)(iv), the term “medication management program” means a program of services, including medicine screening and patient and health care provider education programs, that provides services to minimize—

(i) unnecessary or inappropriate use of prescription drugs; and

(ii) adverse events due to unintended prescription drug-to-drug interactions.

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

(a) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

“(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

“(i) subject to subparagraph (B), the Secretary shall publish the final regulation within the 12-month period that begins on the date of publication of the interim final regulation;

“(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

“(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

“(B) If the Secretary determines before the deadline otherwise established in this paragraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this paragraph, the deadline otherwise established under this paragraph shall be extended for such period (not to exceed 12 months) as the Secretary specifies in such notice.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) STATUS OF PENDING INTERIM FINAL REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

“(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

“(i) such retroactive application is necessary to comply with statutory requirements; or

“(ii) failure to apply the change retroactively would be contrary to the public interest.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

“(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

“(C)(i) Except as provided in clause (ii), a substantive change may not take effect before the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

“(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compli-

ance actions undertaken on or after the date of enactment of this Act.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection:

“(e)(1) Not later than 2 years after the date of enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

“(2) In preparing a report under paragraph (1), the Secretary shall collect—

“(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

“(B) information from medicare contractors that tracks the nature of all communications and correspondence.

“(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.”.

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to

ensure the independence of administrative law judges, including ensuring that such judges are in an office that is functionally and operationally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff).

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A-534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security, and the Secretary a report on such evaluation.

(c) SUBMISSION OF GAO REPORT REQUIRED BEFORE PLAN IMPLEMENTATION.—The Commissioner of Social Security and the Secretary may not implement the plan developed under subsection (a) before the date that is 6 months after the date the report required under subsection (b)(2) is submitted to the Commissioner and the Secretary.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting “, subject to paragraph (2),” before “to judicial review of the Secretary’s final decision”; and

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

“(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

“(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

“(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

“(C) ACCESS TO JUDICIAL REVIEW.—

“(i) IN GENERAL.—If the appropriate review entity—

“(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

“(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

“(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

“(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

“(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

“(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than 1 applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

“(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

“(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, a ‘review entity’ is a panel of no more than 3 members from the Departmental Appeals Board, selected for the purpose of making determinations under this paragraph.”.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting “(A)” after “(h)(1)”; and

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

“(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of

services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.”.

(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL REVIEW.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the access of medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act subsequent to February 29, 2000, the date of the decision of Shalala, Secretary of Health and Human Services, et al. v. Illinois Council on Long Term Care, Inc. (529 U.S. 1 (2000)).

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

(d) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

“(i) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i-3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

“(3) TIMELY COMPLETION OF THE RECORD.—

“(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

“(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

“(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

“(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

“(i) written or testimonial evidence, or both, submitted by the person filing the request,

“(ii) written or oral argument, or both,

“(iii) the decision of, and the record for, the prior level of appeal, and

“(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.”.

(b) USE OF PATIENTS’ MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting “(including the medical records of the individual involved)” after “clinical experience”.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

“(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

“(A) the reasons for the determination, including, as appropriate—

“(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

“(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

“(B) the procedures for obtaining additional information concerning the determination or redetermination; and

“(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.”.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

“(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

“(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

“(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

“(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.”.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting “; NOTICE” after “SECRETARY”; and

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

“(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

“(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

“(B) the procedures for obtaining additional information concerning the decision; and

“(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.”.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking “such information as is required for an appeal” and inserting “the record for the appeal”.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting “(except in the case of a utilization and quality control peer review organization, as defined in section 1152)” after “means an entity or organization that”; and

(ii) by striking the period at the end and inserting the following: “and meets the following requirements:

“(A) GENERAL REQUIREMENTS.—

“(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

“(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

“(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

“(B) INDEPENDENCE REQUIREMENTS.—

“(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

“(I) is not a related party (as defined in subsection (g)(5));

“(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

“(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

“(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent con-

tractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

“(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.”; and

(B) in paragraph (3)(A), by striking “, and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection”.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

“(D) QUALIFICATIONS OF REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).”; and

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

“(g) QUALIFICATIONS OF REVIEWERS.—

“(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

“(A) each individual conducting a review shall meet the qualifications of paragraph (2);

“(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

“(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a ‘reviewing professional’), each reviewing professional meets the qualifications described in paragraph (4).

“(2) INDEPENDENCE.—

“(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

“(i) not be a related party (as defined in paragraph (5));

“(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

“(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

“(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

“(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

“(I) a nonaffiliated individual is not reasonably available;

“(II) the affiliated individual is not involved in the provision of items or services in the case under review;

“(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

“(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

“(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

“(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

“(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

“(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

“(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

“(5) RELATED PARTY DEFINED.—For purposes of this section, the term ‘related party’ means, with respect to a case under this title involving an individual beneficiary, any of the following:

“(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

“(B) The individual (or authorized representative).

“(C) The health care professional that provides the items or services involved in the case.

“(D) The institution at which the items or services (or treatment) involved in the case are provided.

“(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

“(F) Any other party determined under any regulations to have a substantial interest in the case involved.”.

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking “12” and inserting “4”.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A-543) is amended to read as follows:

“(d) EFFECTIVE DATE.—

“(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2004.

“(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003:

“(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

“(B) Subsection (c)(3)(C)(iii) of such section.

“(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

“(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.”.

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A-543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A-534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

“(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

“(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

“(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.”

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

“(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.”

SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

“(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

“(5) AGGRIEVED PARTY DEFINED.—In this section, the term ‘aggrieved party’ means—

“(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

“(B) with respect to a local coverage determination—

“(i) an individual who is entitled to benefits under part A, or enrolled under part B, or both, who is adversely affected by such a determination; or

“(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.”

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting “, including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service” before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 514(d)(2)(B), is amended by adding at the end the following new subsection:

“(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

“(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

“(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term ‘provider local coverage determination request’ means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

“(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

“(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

“(B) each reversal described in subparagraph (A) involves substantially similar material facts;

“(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

“(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

“(4) APPROVAL OR REJECTION OF REQUEST.—

“(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any cov-

erage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

“(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.”

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A-543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2003;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

“CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

“SEC. 1874A. (a) AUTHORITY.—

“(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

“(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

“(A) the entity has demonstrated capability to carry out such function;

“(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

“(C) the entity has sufficient assets to financially support the performance of such function; and

“(D) the entity meets such other requirements as the Secretary may impose.

“(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

“(A) IN GENERAL.—The term ‘medicare administrative contractor’ means an agency, organization, or other person with a contract under this section.

“(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the ‘appropriate’ medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

“(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and beneficiary services functions as follows:

“(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

“(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

“(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

“(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

“(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

“(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

“(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are

necessary to carry out the purposes of this title.

“(5) RELATIONSHIP TO MIP CONTRACTS.—

“(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

“(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

“(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

“(b) CONTRACTING REQUIREMENTS.—

“(1) USE OF COMPETITIVE PROCEDURES.—

“(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

“(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 6 years.

“(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

“(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

“(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

“(3) PERFORMANCE REQUIREMENTS.—

“(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary

shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

“(B) CONSIDERATIONS.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

“(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

“(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

“(ii) shall be used for evaluating contractor performance under the contract; and

“(iii) shall be consistent with the written statement of work provided under the contract.

“(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

“(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

“(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

“(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

“(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

“(A) designate at least 1 different individual to serve as medical director for each State for which such contract performs such function;

“(B) utilize such medical director in the performance of such function; and

“(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.

“(c) TERMS AND CONDITIONS.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

“(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of

identifying situations in which the provisions of section 1862(b) may apply.

“(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

“(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

“(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

“(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

“(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the “False Claims Act”).

“(5) INDEMNIFICATION BY SECRETARY.—

“(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

“(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

“(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

“(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

“(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

“(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

“(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.”.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

“PROVISIONS RELATING TO THE ADMINISTRATION OF PART A”.

(2) Subsection (a) is amended to read as follows:

“(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.”.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking “agreement under this section” and inserting “contract under section 1874A that provides for making payments under this part”.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking “An agreement with an agency or organization under this section” and inserting “A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part”; and

(B) by striking “such agency or organization” and inserting “such medicare administrative contractor” each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

“PROVISIONS RELATING TO THE ADMINISTRATION OF PART B”.

(2) Subsection (a) is amended to read as follows:

“(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.”.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking “carriers” and inserting “medicare administrative contractors”; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking “Each such contract shall provide that the carrier” and inserting “The Secretary”;

(ii) by striking “will” the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting “shall”;

(iii) in subparagraph (B), in the matter before clause (i), by striking “to the policyholders and subscribers of the carrier” and inserting “to the policyholders and subscribers of the medicare administrative contractor”;

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking “if it makes determinations or payments with respect to physicians' services.”; and

(II) by striking “carrier” and inserting “medicare administrative contractor”;

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking “and shall contain” and all that follows through the period; and

(ix) in the seventh sentence, by inserting “medicare administrative contractor,” after “carrier.”;

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking “carrier” and inserting “medicare administrative contractor”; and

(F) in paragraph (7), by striking “the carrier” and inserting “the Secretary” each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking “contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),” and inserting “contract under section 1874A that provides for making payments under this part”;

(C) in paragraph (3)(A), by striking “subsection (a)(1)(B)” and inserting “section 1874A(a)(3)(B)”;

(D) in paragraph (4), by striking “carrier” and inserting “medicare administrative contractor”;

(E) in paragraph (5), by striking “contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier” and “carrier responses” and inserting “contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor” and “contractor responses”, respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking “carrier or carriers” and inserting “medicare administrative contractor or contractors”.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking “Each carrier having an agreement with the Secretary under subsection (a)” and inserting “The Secretary”; and

(ii) by striking “Each such carrier” and inserting “The Secretary”;

(B) in paragraph (3)(A)—

(i) by striking “a carrier having an agreement with the Secretary under subsection (a)” and inserting “medicare administrative contractor having a contract under section 1874A that provides for making payments under this part”; and

(ii) by striking “such carrier” and inserting “such contractor”;

(C) in paragraph (3)(B)—

(i) by striking “a carrier” and inserting “a medicare administrative contractor” each place it appears; and

(ii) by striking “the carrier” and inserting “the contractor” each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking “carriers” and inserting “medicare administrative contractors” each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking “carrier” and inserting “medicare administrative contractor”; and

(B) in paragraph (2), by striking “carrier” and inserting “medicare administrative contractor”.

(9) Subsection (p)(3)(A) is amended by striking “carrier” and inserting “medicare administrative contractor”.

(10) Subsection (q)(1)(A) is amended by striking “carrier”.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

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

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a

plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

“PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

“SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

“(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

“(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

“(2) GAO REVIEW OF METHODOLOGY.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

“(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.”

(2) REPORT.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the So-

cial Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

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

(B) in subparagraph (B), by striking “The amount appropriated” and inserting “Subject to subparagraph (C), the amount appropriated”; and

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

“(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

“(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by \$35,000,000.

“(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.”

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

“(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

“(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

“(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term ‘small provider of services or supplier’ means—

“(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

“(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.”

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

“(c) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of

services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

“(d) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

“(1) of the screens used for identifying claims that will be subject to medical review; or

“(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

“(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term ‘medicare contractor’ includes the following:

“(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

“(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

“(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

“(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

“(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

“(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

“(4) MONITORING OF CONTRACTOR RESPONSES.—

“(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

“(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

“(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

“(B) DEVELOPMENT OF STANDARDS.—

“(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

“(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the

Secretary shall consider the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

“(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

“(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in subsection (e)(3).”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

“(2) If—

“(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

“(i) by the Secretary; or

“(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor’s contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

“(B) the Secretary determines that—

“(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

“(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

“(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: “; MEDICARE PROVIDER OMBUDSMAN”;

(2) by inserting “PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)” after “(a)”;

(3) in paragraph (1), as so redesignated under paragraph (2), by striking “in this section” and inserting “in this subsection”;

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

“(b) MEDICARE PROVIDER OMBUDSMAN.—

“(1) IN GENERAL.—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

“(2) DUTIES.—The Medicare Provider Ombudsman shall—

“(A) provide assistance, on a confidential basis, to entities and individuals providing items and services, including covered drugs under part D, under this title with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

“(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

“(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

“(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

“(3) STAFF.—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.”.

(b) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (42 U.S.C. 1395ee) (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.

(a) DEMONSTRATION ON THE PROVISION OF ADVICE AND ASSISTANCE TO MEDICARE BENEFICIARIES AT LOCAL OFFICES OF THE SOCIAL SECURITY ADMINISTRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this subsection referred to as the “demonstration program”) under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) LOCATIONS.—

(A) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) DEMONSTRATION ON PROVIDING PRIOR DETERMINATIONS.—

(1) ESTABLISHMENT.—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such item or service is furnished to the beneficiary) as to whether the item or service is covered under such title consistent with the applicable requirements of section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) (relating to medical necessity).

(2) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program conducted under paragraph (1).

(B) REPORT.—By not later than January 1, 2006, the Secretary shall submit to Congress a report on such evaluation together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

“(g) CONDUCT OF PREPAYMENT REVIEW.—

“(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

“(2) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

“(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

“(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physi-

cian, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

“(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term ‘random prepayment review’ means a demand for the production of records or documentation absent cause with respect to a claim.”.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

“(h) RECOVERY OF OVERPAYMENTS.—

“(1) USE OF REPAYMENT PLANS.—

“(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

“(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

“(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

“(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

“(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

“(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

“(ii) there is an indication of fraud or abuse committed against the program.

“(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

“(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

“(2) LIMITATION ON RECOUPMENT.—

“(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

“(B) PAYMENT OF INTEREST.—

“(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

“(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

“(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

“(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in section 1889(e).

“(3) PAYMENT AUDITS.—

“(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

“(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

“(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

“(ii) inform the provider of services, physician, practitioner, or supplier of the appeal

rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

“(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

“(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

“(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

“(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

“(6) CONSENT SETTLEMENT REFORMS.—

“(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

“(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

“(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

“(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

“(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

“(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

“(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

“(I) the opportunity for a statistically valid random sample; or

“(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

“(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term ‘consent settlement’ means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or

supplier agrees not to appeal the claims involved.”.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a-7(c)(3)(B)) is amended to read as follows: “Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.”.

TITLE VI—OTHER PROVISIONS

SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)) is amended—

(1) in the paragraph heading, by striking “FISCAL YEARS 2001 AND 2002” and inserting “CERTAIN FISCAL YEARS”;

(2) in subparagraph (A)—

(A) in clause (i)—

(i) by striking “paragraph (2)” and inserting “paragraphs (2) and (3)”;

(ii) by striking “and” at the end;

(B) in clause (i), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(iii) for fiscal year 2004, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

“(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

“(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

“(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

“(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2004; and

“(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005.”; and

(3) in subparagraph (C)—

(A) in the subparagraph heading, by striking “AFTER FISCAL YEAR 2002” and inserting “FOR OTHER FISCAL YEARS”; and

(B) by striking “2003 or” and inserting “2003, fiscal year 2006, or”.

(b) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)), as amended by paragraph (1), is amended—

(1) in subparagraph (A), by inserting “and except as provided in subparagraph (C)” after “paragraph (2)”;

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

“(C) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

“(i) IN GENERAL.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by substituting ‘49’ for ‘32’ in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, 2002, and 2003.

“(ii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2005, or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i).”.

(c) CONFORMING AMENDMENT.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r-4(f)(3)) is amended by inserting “, paragraph (4),” after “subparagraph (B)”.

SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE UNDER THE MEDICAID PROGRAM FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(5) (42 U.S.C. 1396r-4(f)(5)) is amended—

(1) by striking “In the case of” and inserting the following:

“(A) IN GENERAL.—In the case of”;

(2) by adding at the end the following:

“(B) INCREASE IN FLOOR FOR FISCAL YEARS 2004 AND 2005.—

“(i) FISCAL YEAR 2004.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State’s total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State’s total amount of expenditures under such plan for such assistance during such fiscal year.

“(ii) FISCAL YEAR 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State’s total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

“(iii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2005.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subsection without regard to the DSH allotments determined under this subparagraph.”

(b) ALLOTMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following:

“(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of either such fiscal year, the Secretary shall—

“(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children’s hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

“(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would

have been made if such waiver had not been revoked or terminated.”

(2) TREATMENT OF INSTITUTIONS FOR MENTAL DISEASES.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r-4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting “(subject to paragraph (3))” after “the lesser of the following”; and

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

“(3) SPECIAL RULE.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.”

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATENESS OF PAYMENT ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID PROGRAM.

Section 1923 (42 U.S.C. 1396r-4) is amended by adding at the end the following new subsection:

“(j) ANNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to submit an annual report that—

“(1) identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year; and

“(2) includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.”

SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: “(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)”

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)) is amended by adding at the end the following:

“(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.”

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”; and

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

“(4)(A) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver authorized by the Secretary) for aliens who are lawfully resid-

ing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

“(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

“(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

“(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

“(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).”

(b) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

“(C) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.”

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

“(i) CONSUMER OMBUDSMAN ACCOUNT.—“(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the ‘Consumer Ombudsman Account’ (in this subsection referred to as the ‘Account’).

“(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

“(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year beginning with fiscal year 2005, the amount described in subparagraph (B) for such fiscal year for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

“(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in this subparagraph for a fiscal year is the amount equal to the product of—

“(i) \$1; and

“(ii) the total number of individuals receiving benefits under this title for the calendar year ending on December 31 of the preceding fiscal year.”

(b) CONFORMING AMENDMENT.—Section 4360(g) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b-4(g)) is amended to read as follows:

“(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumer Ombudsman Account in accordance with section 1817(i) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.”

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for

the transitional assistance prescription drug card program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D-19 of the Social Security Act (as added by section 101).

(b) **INDIVIDUAL DESCRIBED.**—An individual is described in this subsection if the individual does not qualify for the transitional assistance prescription drug card program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D-19 of the Social Security Act solely as a result of the application of an assets test to the individual.

(c) **REPORT.**—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(d) **DEFINITIONS.**—In this section:

(1) **COVERED DRUGS.**—The term “covered drugs” has the meaning given that term in section 1860D(a)(D) of the Social Security Act.

(2) **QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARY; QUALIFYING INDIVIDUAL.**—The terms “qualified medicare beneficiary”, “specified low-income medicare beneficiary” and “qualifying individual” have the meaning given those terms under section 1860D-19 of the Social Security Act.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

“TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT

“SEC. 2201. DEFINITIONS.

“In this title, the following definitions apply:

“(1) **ELIGIBLE PROJECT COSTS.**—The term ‘eligible project costs’ means amounts substantially all of which are paid by, or for the account of, an obligor in connection with a project, including the cost of—

“(A) development phase activities, including planning, feasibility analysis, revenue forecasting, environmental study and review, permitting, architectural engineering and design work, and other preconstruction activities;

“(B) construction, reconstruction, rehabilitation, replacement, and acquisition of facilities and real property (including land related to the project and improvements to land), environmental mitigation, construction contingencies, and acquisition of equipment;

“(C) capitalized interest necessary to meet market requirements, reasonably required reserve funds, capital issuance expenses, and other carrying costs during construction;

“(D) major medical equipment determined to be appropriate by the Secretary; and

“(E) refinancing projects or activities that are otherwise eligible for financial assistance under subparagraphs (A) through (D).

“(2) **FEDERAL CREDIT INSTRUMENT.**—The term ‘Federal credit instrument’ means a secured loan, loan guarantee, or line of credit authorized to be made available under this title with respect to a project.

“(3) **INVESTMENT-GRADE RATING.**—The term ‘investment-grade rating’ means a rating category of BBB minus, Baa3, or higher assigned by a rating agency to project obligations offered into the capital markets.

“(4) **LENDER.**—The term ‘lender’ means any non-Federal qualified institutional buyer (as

defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known as Rule 144A(a) of the Securities and Exchange Commission and issued under the Securities Act of 1933 (15 U.S.C. 77a et seq.)), including—

“(A) a qualified retirement plan (as defined in section 4974(c) of the Internal Revenue Code of 1986) that is a qualified institutional buyer; and

“(B) a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986) that is a qualified institutional buyer.

“(5) **LINE OF CREDIT.**—The term ‘line of credit’ means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

“(6) **LOAN GUARANTEE.**—The term ‘loan guarantee’ means any guarantee or other pledge by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

“(7) **LOCAL SERVICER.**—The term ‘local servicer’ means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

“(8) **OBLIGOR.**—The term ‘obligor’ means a party primarily liable for payment of the principal of or interest on a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

“(9) **PROJECT.**—The term ‘project’ means any project that is designed to improve the health care infrastructure, including the construction, renovation, or other capital improvement of any hospital, medical research facility, or other medical facility or the purchase of any equipment to be used in a hospital, research facility, or other medical research facility.

“(10) **PROJECT OBLIGATION.**—The term ‘project obligation’ means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

“(11) **RATING AGENCY.**—The term ‘rating agency’ means a bond rating agency identified by the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

“(12) **SECURED LOAN.**—The term ‘secured loan’ means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

“(13) **STATE.**—The term ‘State’ has the meaning given the term in section 101 of title 23, United States Code.

“(14) **SUBSIDY AMOUNT.**—The term ‘subsidy amount’ means the amount of budget authority sufficient to cover the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).

“(15) **SUBSTANTIAL COMPLETION.**—The term ‘substantial completion’ means the opening of a project to patients or for research purposes.

“SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

“(a) **ELIGIBILITY.**—To be eligible to receive financial assistance under this title, a project shall meet the following criteria:

“(1) **APPLICATION.**—A State, a local servicer identified under section 2205(a), or the entity

undertaking a project shall submit a project application to the Secretary.

“(2) **ELIGIBLE PROJECT COSTS.**—To be eligible for assistance under this title, a project shall have total eligible project costs that are reasonably anticipated to equal or exceed \$40,000,000.

“(3) **SOURCES OF REPAYMENTS.**—Project financing shall be repayable, in whole or in part, from reliable revenue sources as described in the application submitted under paragraph (1).

“(4) **PUBLIC SPONSORSHIP OF PRIVATE ENTITIES.**—In the case of a project that is undertaken by an entity that is not a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be publicly sponsored or sponsored by an entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.

“(b) **SELECTION AMONG ELIGIBLE PROJECTS.**—

“(1) **ESTABLISHMENT.**—The Secretary shall establish criteria for selecting among projects that meet the eligibility criteria specified in subsection (a).

“(2) **SELECTION CRITERIA.**—

“(A) **IN GENERAL.**—The selection criteria shall include the following:

“(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

“(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverages, to ensure repayment.

“(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

“(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

“(v) The extent to which the project uses or results in new technologies.

“(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

“(vii) The extent to which the project helps maintain or protect the environment.

“(B) **SPECIFIC REQUIREMENTS.**—The selection criteria shall require that a project applicant—

“(i) be engaged in research in the causes, prevention, and treatment of cancer;

“(ii) be designated as a cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State; and

“(iii) be located in a State that, on the date of enactment of this title, has a population of less than 3,000,000 individuals.

“(C) **RATING LETTER.**—For purposes of subparagraph (A)(ii), the Secretary shall require each project applicant to provide a rating letter from at least 1 rating agency indicating that the project’s senior obligations have the potential to achieve an investment-grade rating with or without credit enhancement.

“SEC. 2203. SECURED LOANS.

“(a) **IN GENERAL.**—

“(1) **AGREEMENTS.**—Subject to paragraphs (2) through (4), the Secretary may enter into agreements with 1 or more obligors to make secured loans, the proceeds of which shall be used—

“(A) to finance eligible project costs;

“(B) to refinance interim construction financing of eligible project costs; or

“(C) to refinance existing debt or prior project obligations;

“(2) LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing under paragraph (1)(B) later than 1 year after the date of substantial completion of the project.

“(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

“(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

“(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) prior to the obligations receiving an investment-grade rating; and

“(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

“(b) TERMS AND LIMITATIONS.—

“(1) IN GENERAL.—A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

“(2) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

“(3) PAYMENT.—The secured loan—

“(A) shall—

“(i) be payable, in whole or in part, from reliable revenue sources; and

“(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

“(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

“(4) INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on marketable United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

“(5) MATURITY DATE.—The final maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

“(6) NONSUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

“(7) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

“(c) REPAYMENT.—

“(1) SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayment sources.

“(2) COMMENCEMENT.—Scheduled loan repayments of principal or interest on a secured loan under this section shall commence not later than 5 years after the date of substantial completion of the project.

“(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repay-

ments under this section shall include any revenue generated by the project.

“(4) DEFERRED PAYMENTS.—

“(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary may, subject to subparagraph (C), allow the obligor to add unpaid principal and interest to the outstanding balance of the secured loan.

“(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

“(i) continue to accrue interest in accordance with subsection (b)(4) until fully repaid; and

“(ii) be scheduled to be amortized over the remaining term of the loan beginning not later than 10 years after the date of substantial completion of the project in accordance with paragraph (1).

“(C) CRITERIA.—

“(i) IN GENERAL.—Any payment deferral under subparagraph (A) shall be contingent on the project meeting criteria established by the Secretary.

“(ii) REPAYMENT STANDARDS.—The criteria established under clause (i) shall include standards for reasonable assurance of repayment.

“(5) PREPAYMENT.—

“(A) USE OF EXCESS REVENUES.—Any excess revenues that remain after satisfying scheduled debt service requirements on the project obligations and secured loan and all deposit requirements under the terms of any trust agreement, bond resolution, reimbursement agreement, credit agreement, loan agreement, or similar agreement securing project obligations may be applied annually to prepay the secured loan without penalty.

“(B) USE OF PROCEEDS OF REFINANCING.—The secured loan may be prepaid at any time without penalty, regardless of whether such repayment is from the proceeds of refinancing from non-Federal funding sources.

“(6) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan secured under this title under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the project of—

“(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

“(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

“(C)(i) unique research resources (such as population databases); or

“(ii) an affiliation with an entity that has unique research resources.

“(d) SALE OF SECURED LOANS.—

“(1) IN GENERAL.—Subject to paragraph (2), as soon as practicable after substantial completion of a project and after notifying the obligor, the Secretary may sell to another entity or reoffer into the capital markets a secured loan for the project if the Secretary determines that the sale or reoffering can be made on favorable terms.

“(2) CONSENT OF OBLIGOR.—In making a sale or reoffering under paragraph (1), the Secretary may not change the original terms and conditions of the secured loan without the written consent of the obligor.

“(e) LOAN GUARANTEES.—

“(1) IN GENERAL.—The Secretary may provide a loan guarantee to a lender in lieu of making a secured loan if the Secretary de-

termines that the budgetary cost of the loan guarantee is substantially the same as that of a secured loan.

“(2) TERMS.—The terms of a guaranteed loan shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

“SEC. 2204. LINES OF CREDIT.

“(a) IN GENERAL.—

“(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make available lines of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2202.

“(2) USE OF PROCEEDS.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

“(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

“(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating from at least 1 rating agency.

“(b) TERMS AND LIMITATIONS.—

“(1) IN GENERAL.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

“(2) MAXIMUM AMOUNTS.—

“(A) TOTAL AMOUNT.—The total amount of the line of credit shall not exceed 33 percent of the reasonably anticipated eligible project costs.

“(B) 1-YEAR DRAWS.—The amount drawn in any 1 year shall not exceed 20 percent of the total amount of the line of credit.

“(3) DRAWS.—Any draw on the line of credit shall represent a direct loan and shall be made only if net revenues from the project (including capitalized interest, any debt service reserve fund, and any other available reserve) are insufficient to pay the costs specified in subsection (a)(2).

“(4) INTEREST RATE.—The interest rate on a direct loan resulting from a draw on the line of credit shall be not less than the yield on 30-year marketable United States Treasury securities as of the date on which the line of credit is obligated.

“(5) SECURITY.—The line of credit—

“(A) shall—

“(i) be payable, in whole or in part, from reliable revenue sources; and

“(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

“(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

“(6) PERIOD OF AVAILABILITY.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

“(7) RIGHTS OF THIRD-PARTY CREDITORS.—

“(A) AGAINST FEDERAL GOVERNMENT.—A third-party creditor of the obligor shall not have any right against the Federal Government with respect to any draw on the line of credit.

“(B) ASSIGNMENT.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders’ behalf.

“(8) NONSUBORDINATION.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

“(9) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

“(10) RELATIONSHIP TO OTHER CREDIT INSTRUMENTS.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2203 of an amount that, combined with the amount of the line of credit, exceeds 100 percent of eligible project costs.

“(c) REPAYMENT.—

“(1) TERMS AND CONDITIONS.—The Secretary shall establish repayment terms and conditions for each direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

“(2) TIMING.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

“(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

“SEC. 2205. PROJECT SERVICING.

“(a) REQUIREMENT.—The State in which a project that receives financial assistance under this title is located may identify a local servicer to assist the Secretary in servicing the Federal credit instrument made available under this title.

“(b) AGENCY; FEES.—If a State identifies a local servicer under subsection (a), the local servicer—

“(1) shall act as the agent for the Secretary; and

“(2) may receive a servicing fee, subject to approval by the Secretary.

“(c) LIABILITY.—A local servicer identified under subsection (a) shall not be liable for the obligations of the obligor to the Secretary or any lender.

“(d) ASSISTANCE FROM EXPERT FIRMS.—The Secretary may retain the services of expert firms in the field of project finance to assist in the underwriting and servicing of Federal credit instruments.

“SEC. 2206. STATE AND LOCAL PERMITS.

“The provision of financial assistance under this title with respect to a project shall not—

“(1) relieve any recipient of the assistance of any obligation to obtain any required State or local permit or approval with respect to the project;

“(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

“(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

“SEC. 2207. REGULATIONS.

“The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

“SEC. 2208. FUNDING.

“(a) FUNDING.—

“(1) IN GENERAL.—There are authorized to be appropriated to carry out this title, \$49,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

“(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than \$2,000,000 for each of fiscal years 2004 through 2008.

“(b) CONTRACT AUTHORITY.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed to be acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

“(c) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

“SEC. 2209. REPORT TO CONGRESS.

“Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving, or have received, assistance under this title, including a recommendation as to whether the objectives of this title are best served—

“(1) by continuing the program under the authority of the Secretary;

“(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program; or

“(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.”.

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

“CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

“SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

“(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

“(A) the acquisition of land necessary for the capital improvements;

“(B) the renovation or modernization of any building;

“(C) the acquisition or repair of fixed or major movable equipment; and

“(D) such other project expenses as the Secretary determines appropriate.

“(2) AUTHORITY TO GUARANTEE LOANS.—

“(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

“(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

“(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed \$5,000,000.

“(c) FUNDING LIMITATIONS.—

“(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to

the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed \$50,000,000 per year.

“(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed \$250,000,000 per year.

“(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

“(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed \$50,000, for purposes of capital assessment and business planning.

“(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed \$2,500,000 per year.

“(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2008.”.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s-3) is amended by adding at the end the following new paragraph:

“(14)(A) The term ‘rural entity’ includes—

“(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

“(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

“(I) a county that is not part of a metropolitan statistical area; or

“(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

“(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

“(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

“(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).”.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q-2) is amended—

(1) in subsection (b)(2)(D), by inserting “or 1603(a)(2)(B)” after “1601(a)(2)(B)”; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking “section 1601(a)(2)(B)” and inserting “sections 1601(a)(2)(B) and 1603(a)(2)(B)”; and

(B) in paragraph (2)(A), by inserting “or 1603(a)(2)(B)” after “1601(a)(2)(B)”.

SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, \$250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in paragraph (1) or (2) of subsection (b). Funds appropriated under the preceding sentence shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use \$167,000,000 of such

amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use \$33,000,000 of such amount to make allotments for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in that fiscal year bears to the total of such numbers for all such States for such fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both paragraphs for a fiscal year.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, and to the State, such amounts (subject to the total amount available from such allotments) as the local governments, hospitals, providers, or State demonstrate were incurred for the provision of such services during that fiscal year.

(2) LIMITATION ON STATE USE OF FUNDS.—Funds paid to a State from allotments made under subsection (b) for a fiscal year may only be used for making payments to local governments, hospitals, or other providers for costs incurred in providing emergency health services to undocumented aliens or for State costs incurred with respect to the provision of emergency health services to such aliens.

(3) INCLUSION OF COSTS INCURRED WITH RESPECT TO CERTAIN ALIENS.—Uncompensated emergency health services furnished to aliens who have been allowed to enter the United States for the sole purpose of receiving emergency health services may be included in the determination of costs incurred by a State, local government, hospital, or other provider with respect to the provision of such services.

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which States, local governments, hospitals, or other providers located in the State may apply for payments from allotments made under subsection (b) for a fiscal year for uncompensated emergency health services furnished to undocumented aliens during that fiscal year.

(B) INCLUSION OF MEASURES TO COMBAT FRAUD.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that fraudulent payments are not made from the allotments determined under subsection (b).

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) shall allow for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term “hospital” has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms “Indian tribe” and “tribal organization” have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) PROVIDER.—The term “provider” includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

(4) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(5) STATE.—The term “State” means the 50 States and the District of Columbia.

SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by striking “and” at the end; and

(B) by striking subclause (III), and inserting the following new subclauses:

“(III) for fiscal year 2004, the limit for fiscal year 2003 increased by \$10,000,000;

“(IV) for fiscal year 2005, the limit for fiscal year 2003 increased by \$15,000,000;

“(V) for fiscal year 2006, the limit for fiscal year 2003 increased by \$25,000,000; and

“(VI) for each fiscal year after fiscal year 2006, the limit for fiscal year 2003.”; and

(2) in clause (ii)—

(A) in subclause (VI), by striking “and” at the end;

(B) in subclause (VII)—

(i) by striking “each fiscal year after fiscal year 2002” and inserting “fiscal year 2003”; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

“(VIII) for fiscal year 2004, \$170,000,000;

“(IX) for fiscal year 2005, \$175,000,000;

“(X) for fiscal year 2006, \$185,000,000; and

“(XI) for each fiscal year after fiscal year 2006, not less than \$150,000,000 and not more than \$160,000,000.”.

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) IN GENERAL.—Section 3729(a) of title 31, United States Code, is amended—

(1) by striking “\$5,000” and inserting “\$7,500”; and

(2) by striking “\$10,000” and inserting “\$15,000”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)), in the matter following paragraph (7), is amended—

(1) by striking “\$10,000” each place it appears and inserting “\$12,500”;

(2) by striking “\$15,000” and inserting “\$18,750”; and

(3) striking “\$50,000” and inserting “\$62,500”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 614. EXTENSION OF CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking “September 30, 2003” and inserting “September 30, 2013”.

Mr. GRASSLEY. Mr. President, the technical corrections in this modification obviously have been agreed to by Senator BAUCUS or I would not have offered it, and they are not controversial. The corrected items in this modification are technical in nature. It merely perfects policies in the Finance Committee’s reported mark that were drafted incorrectly in S. 1. The corrected items also reflect drafting changes that, while small, were important from CBO’s perspective in getting us a complete score. All of these technical changes are incorporated now into this modified version of S. 1.

The new version also includes an official line-by-line score from the Congressional Budget Office. I am looking forward to getting on to amendments at this point. I repeat what I said yesterday: My hope is the spirit of comity and consensus building that existed in the Finance Committee last week will be and can be, and I am surely going to work for it to be, replicated here on the Senate floor. The Finance Committee members reached across party lines to arrive at that consensus. For some it was very difficult. But the final vote showed a lot of give and take because that vote out of committee was 16 to 5. I hope that same spirit will prevail here today and in the coming days this week and next week that we are on the bill.

There was another part of the consent I did not ask. I now ask unanimous consent the amendment be agreed to—our professional staff has some disagreement whether or not I should be making that motion at this point, so I will not.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, the Senator from Michigan is now going to offer her amendment. We are willing to enter into a time agreement on the amendment. There are a number of meetings at the White House, I am told, that prevent our arriving at a definite time for the amendment today. I have spoken to the staff on both sides, and maybe at 3:15 we could have a vote.

Members should keep that in mind, that we may be able to do that.

There is nothing definite at this stage. I want the record to reflect we are not trying to stall movement of this bill. We have this amendment, this important amendment. We are ready to vote on it earlier than 3:15. But because of the White House calling Senators down, we will be unable to do that.

Mr. GRASSLEY. Mr. President, in addition to what the Senator expressed, it is a desire on our part that we would have some votes yet today and that we would like to move along very quickly. I think the spirit he has set is one that is shared on our side, even to the point of being specific statements from our leadership, the extent to which they would hope to have some votes today.

I yield the floor.

Mr. REID. It was suggested earlier today that we would rotate back and forth on amendments. That is fine. I think we have more amendments than you have, but if that is the case, we are happy to alternate back and forth.

Mr. GRASSLEY. Mr. President, if I may further add to what the Senator said, for our part, we would like to have a very general rule that we would alternate back and forth, but it is also our belief on this side that we would give great deference to the other side to offer amendments, two Democratic or three Democratic amendments in order so we could be very flexible on that. We did want to reserve and provide some predictability to the order on the floor because there might be some Members on the Republican side who would like to offer an amendment, and they want some certainty when that would be done.

The PRESIDING OFFICER. The Senator from Michigan.

AMENDMENT NO. 931

Ms. STABENOW. Mr. President, I send an amendment to the desk on behalf of myself, Senators BOXER, BOB GRAHAM, ROCKEFELLER, HARKIN, CANTWELL, KERRY, BINGAMAN, JACK REED, CLINTON, and MIKULSKI. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW], for herself, Mrs. BOXER, Mr. GRAHAM of Florida, Mr. ROCKEFELLER, Mr. HARKIN, Ms. CANTWELL, Mr. KERRY, Mr. BINGAMAN, Mr. REED, Mrs. CLINTON, and Ms. MIKULSKI, proposes an amendment numbered 931.

Ms. STABENOW. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To require that the Medicare plan, to be known as the Medicare Guaranteed Option, be available to all eligible beneficiaries in every year)

Beginning on page 74, strike line 10 and all that follows through page 84, line 3, and insert the following:

“(e) MEDICARE GUARANTEED OPTION.—

“(1) ACCESS.—

“(A) IN GENERAL.—The Administrator shall enter into a contract with an entity in each area (established under section 1860D-10) to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a Medicare Advantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)). An entity may be awarded a contract for more than 1 area but the Administrator may enter into only 1 such contract in each such area.

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

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

“(D) SAME TIMEFRAME AS MEDICARE PRESCRIPTION DRUG PLANS.—The Administrator shall apply similar timeframes for the submission of bids and entering into to contracts under this subsection as the Administrator applies to Medicare Prescription Drug plans.

“(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(A), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D-17(c) before any adjustment under paragraph (2) of such section) of the monthly national average premium (as computed under section 1860D-15 before any adjustment under subsection (b) of such section) for the year.

“(3) PAYMENTS UNDER THE CONTRACT.—

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

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

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

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

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

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

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

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

“(4) TERM OF CONTRACT.—A contract entered into under paragraph (1)(A) shall be for a period of at least 2 years but not more than 5 years.

“(5) NO EFFECT ON ACCESS REQUIREMENTS.—The contract entered into under subparagraph (1)(A) shall be in addition to the plans required under subsection (d)(1).

“(6) AUTHORITY TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to eligible beneficiaries enrolled in a contract under paragraph (1)(A) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a Medicare Advantage plan (with respect to qualified prescription drug coverage), the Administrator may adjust the requirements or payments under such a contract to eliminate such excess.

Ms. STABENOW. Mr. President, first of all, before explaining the amendment, I commend my colleagues for their leadership on the Finance Committee. They have been working very diligently—the chairman, Senator GRASSLEY, and the ranking member, Senator BAUCUS, and members on both sides of the aisle. I commend them for bringing forward one of the most critical issues affecting American people, American families, American seniors today. While we may disagree on specifics and on what is the best approach, I very much commend them for giving us the opportunity to debate this critical issue and for the hard work that has gone on, on both sides.

My amendment is a simple one. It would provide another choice of prescription drug plans for seniors on Medicare. In fact, it would provide the choice the majority of seniors want to make on Medicare.

The underlying bill allows seniors to choose a prescription drug plan, but only if the plan is one offered by a private insurance company. My amendment simply allows seniors to get their prescription drugs through the Medicare Program. It is creating one more option. The legislation before us tries to expand health care choices for people on Medicare. Regrettably, it does not provide the full range of choices for seniors.

Without my amendment, we are not in fact providing the full range of choices, including the one for which the seniors are asking. My amendment will allow seniors the choice to get their prescriptions filled within traditional Medicare, to choose a private prescription drug plan, or enroll in a PPO or an HMO. This range of choice will foster competition among the different plans and allow our seniors to make the best possible choice for themselves. This amendment puts all of the plans on the same footing and does not favor one over the other.

I think it is also important to note that the private plans described in the bill don't exist today. In fact, Robert Reischauer was quoted recently in the New York Times saying, “Private drug-only plans don't exist in nature.” They don't currently exist in nature. So we are designing a system around plans that do not currently exist.

Medicare does exist. A Medicare plan is one that we know we can put together and that seniors can count on, at the same time giving the opportunity for new plans to be created, as

well as the structures of HMOs and PPOs.

I also think this plan could actually save the Federal Government dollars, and certainly the record would reflect that. There is ample objective evidence that providing health care through the Medicare Program is more efficient than through the private sector. This is one area where the evidence is clear, based on various points of information. Let me just share some with you.

On May 5, 2003, the New York Times reported on findings by MedPAC, our own nonpartisan advisory plan. MedPAC discovered that private health plan fees are about 15 percent higher than Medicare. The Center for Studying Health Systems Change has also made similar findings. So we know that if we go to private plans, on average, services will be about 15 percent higher—more costly for fees for services. Surgeries, they found, were about 26 percent more. Radiology was about 19 percent more. Hospital and nursing home visits and consultations were 9 percent more. On average, we know it doesn't in fact cost less to provide services to private plans. Independent, nonpartisan organizations have found that in fact costs more.

Also, using private plans would likely cost additional dollars. In the year 2000, our own General Accounting Office estimated that payments to Medicare+Choice plans—and those are the Medicare HMOs that were set up in 1997—exceeded the costs that would have been incurred for treating patients directly through traditional Medicare by an annual average of 13.2 percent.

So, again, we have a situation where our own nonpartisan, objective General Accounting Office said that providing services through Medicare HMOs actually cost, on average, 13.2 percent more than the same service offered under traditional Medicare, where seniors get to select their own doctors and have the dependability of knowing that Medicare will be there.

Thirdly, private plans are not necessarily more efficient than Medicare. The inspector general of the Department of Health and Human Services found that HMOs that contract with Medicare, on average, spent 15 percent of their revenue on administrative costs rather than on health care. In fact, we know those numbers can be even higher in other private sector plans. Dollars have been put aside in this plan to cover higher administrative costs. Some managed care systems spend as much as 32 percent of their revenue. That means that for every precious dollar we have that we want to help seniors pay for their medicine, about one-third of that could go to administration.

By contrast, the Medicare plan spends only 2 percent of its budget on administrative overhead. On average, a private HMO—and we realize more plans are being developed under this proposal than just HMOs, but if we

look at what we have to go on in terms of the differences, it is 2 percent administrative costs under Medicare and an average of 15 percent for HMOs. And we know that in some areas, in fact, it is even higher administrative costs for other private insurance plans.

Furthermore, the enrollment experience with private plans in Medicare has certainly not been stellar. In the past 5 years, 2.5 million seniors have been dropped by their Medicare HMO. As I have indicated before, one of those in fact was my own mother in Lansing, MI, who had a very positive experience under a Medicare HMO. But the decision was made, for financial reasons, to no longer cover Medicare recipients. She lost her plan and her doctor, and she was left to figure out how else she would be receiving care under Medicare.

In 2002, three plans in Michigan dropped out of Medicare+Choice altogether, while two dropped significant numbers of enrollees. More than 31,000 seniors in Michigan have been dropped just since 2002. What does that mean in real terms for people? It means that they went into a system, they had a doctor, they were within a certain kind of health care system; then the private managed care plan decided to pull out, and they were then left to go find another plan, actually another doctor, and another way of providing health care.

Only 8 of 83 counties in Michigan now have private Medicare HMO plans, and all of them are concentrated in one area, southeastern Michigan, around metro Detroit, which means that those in the Upper Peninsula of our State don't have that choice. I expect it would be very difficult for them to find a private sector plan, even into the future, in northern Michigan, the Upper Peninsula, or the west side of the State. Right now, the only option is obviously around metro Detroit. None of the remaining Medicare HMOs in Michigan is accepting new enrollees.

One Michigan provider even chose to pay a \$25,000 fine to get out of Medicare+Choice and stop serving seniors immediately rather than go through the official withdrawal process. That requires more than 3 months of notice of intent to withdraw. By pulling out immediately, this plan left our seniors in the lurch with very little transition time to explore other ways in order to be able to get their health coverage.

Because of the poor records of the Medicare+Choice plan, almost 9 out of 10 seniors—basically 89 percent—have decided to stay in traditional Medicare. I believe they ought to have the choice to do that. That is what my amendment is all about. It is saying to those right now who have had a choice of a private managed care plan or traditional Medicare since 1997, who have chosen to stay with traditional Medicare, to choose their own doctor, to know that regardless of where they live they will have the dependability, the

stability of Medicare, it will be there for those individuals who have chosen overwhelmingly to stay in traditional Medicare—89 percent.

Any one of us would love that kind of a percentage when people are choosing in an election. Eighty-nine percent of the seniors today have said they want traditional Medicare. Yet this choice they have made is not available to them if there are two or more private sector plans available in their region. Essentially, unfortunately, what the current plan says is you have made your choice; we do not like your choice; pick again. My amendment would guarantee seniors would be able to have that choice.

I know some colleagues strongly believe that moving seniors into the private sector is the best way to provide them prescription drug coverage. While I respectfully disagree with this premise, I think it is a good idea to provide private sector options for those who desire them.

Back to my own family, I think my mother should have that choice, and she should be able to go into Medicare+Choice or another managed care plan if she so desires. I absolutely agree with that if it works for them.

The question is whether the Federal Government should force seniors into a plan, whether it is a private insurance plan or traditional Medicare. Should we be deciding what our seniors should have for their prescription drug coverage? Should we make that choice or should they make the choice? That is why my amendment is so important. It will allow seniors to choose the appropriate plan for them, not the Federal Government.

I have heard a lot of arguments that we should provide seniors with the same options that Members of Congress and Federal employees have in the Federal Employees Health Benefits Plan. Under that plan, we have several options ranging from fee for service to PPOs to HMOs. If we like one of those options—and we choose that option, by the way—the Federal Government does not come in and say, If you work for the Senate, you cannot have option A, you can only get B, C, D, and only A under certain circumstances. We say here is the range of options; you select the one that works for you. If we like the one we selected, we can stay in that plan as long as we want. As long as we are covered by the Federal employees health plan, we can choose that plan. We are never forced to switch plans.

Mr. President, can you imagine if we were living under the plan we are asking seniors to live under; if every employee had to switch back and forth, potentially, depending on what was offered in the private sector, rather than remaining with the plan they desired? We have never been forced to switch plans ourselves. It should be the same for our seniors. If we do not have to switch plans year to year, then seniors should not have to switch either.

My guess is most of us like the plans we are in and probably want to stay with them. Certainly, if we do not, we have the opportunity to change. But the last thing we want to do is switch health plans every year or every other year and try to leaf through hundreds of pages of brochures to evaluate the benefits of a new plan. I, for one, find it is difficult to find the time to do that. I cannot imagine anyone would want the chore of going through every year or every other year all of the paperwork to figure out what is best for them, particularly if they like the plan they are in.

Many seniors want stability. They seek a good, solid, guaranteed health plan where they can see their own doctors. There are some seniors who prefer to experiment with private plans, and they should be given that option. But all seniors should have all options, and that is what my amendment would do. It would make sure the choice is in the hands of our seniors.

Again, this approach is within the framework of the bill. It is within the \$400 billion that has been carved out within the budget resolution. It is within the framework of the benefits structure that has been designed by the committee. This amendment does not change anything other than to say every senior should have the option, as 89 percent of them have chosen to do, to not only have their own doctor under Medicare, but to have a prescription drug plan under Medicare regardless of where they live, and a plan they can count on and depend on.

Again, I commend my colleagues who have been working diligently on this issue. I know it has been a challenge for everyone. I believe this amendment does exactly what the seniors of America want and allows all of us to enthusiastically embrace this proposal as being the right proposal.

I hope my colleagues will support my amendment to offer one more choice to seniors. It builds on the structure of this bipartisan plan and provides more choices.

I know many of us believe this bill can be improved. Outside objective critics have even used stronger language about the way this is restricted in the bill. For example, former CBO Director Robert Reischauer said:

The benefit is rather skimpy and has a bizarre structure. It is an insurance structure that exists nowhere in the private sector or in nature.

Through this amendment we will have a structure that makes sense, that is dependable, that is explainable, that is simple and straightforward, that provides all range of options to seniors so they can decide what it is they wish to do in terms of prescription drug coverage.

Mr. President, I have a letter from the National Committee to Preserve Social Security and Medicare. I will read a portion of it:

On behalf of the millions of members and supporters of the National Committee to

Preserve Social Security and Medicare, I am writing in support of your "Medicare Guaranteed Option" amendment to S. 1. Since the current Senate prescription drug bill, S. 1, wants to offer seniors choices, your amendment would offer seniors real choices because they would have the choice of what they really want, which is a defined benefit under Medicare.

I ask unanimous consent that this letter be printed in the RECORD.

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

June 17, 2003.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATOR STABENOW: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare (NCPSSM), I am writing in support of your "Medicare Guaranteed Option" amendment to S. 1. Since the current Senate prescription drug bill, S. 1, wants to offer seniors choices, your amendment would offer seniors real choices because they would have the choice of what they really want, which is defined benefit under Medicare.

We understand that your amendment would allow traditional Medicare to be an option that stands side-by-side next to the other two or more private plans that are required to be in that region. Instead of the current requirement that Medicare stand as a fall back, only if there are no private plans in the area, it would allow Medicare to be a third choice for seniors who prefer to get their benefits through traditional Medicare. We agree that seniors should have the right to select the option in which they are most comfortable, and for many, that choice might be to stay with traditional Medicare versus one of private plans that are located within their region.

We applaud your efforts and dedication on behalf of America's seniors, and appreciate your continued leadership on this issue. We look forward to continuing to work with you.

Sincerely,

BARBARA B. KENNELLY,
President.

Ms. STABENOW. I thank the Chair. Mr. President, again, I urge my colleagues to join in this amendment. I am hopeful we can join together enthusiastically in embracing a system that has worked since 1965 for our seniors. I hope also we can join together to improve it, not only prescription drug coverage, but ways to minimize paperwork and focus more on prevention, as the Secretary of HHS has suggested.

There are many opportunities for us to improve within the structure of Medicare a plan that is focused more on prevention, to eliminate the paperwork, and to do it together and still provide our seniors with the choice for which they are asking.

In conclusion, I ask unanimous consent to add Senator LEVIN, Senator KOHL, and Senator DODD as cosponsors of my amendment.

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

Ms. STABENOW. I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, first, I congratulate the Senator from Michi-

gan. She has worked very hard and, I might add, effectively in helping make this a better bill.

Everyone in this body wants legislation passed that gives good, solid prescription drug benefits to seniors.

The debate is somewhat over delivery; that is, how we set the plan up, who provides the benefits and so on. The bottom line is the same for all of us. We want good, solid prescription drug benefits for seniors.

The Senator from Michigan is probably as well-versed in this subject and more of an advocate for seniors than any other Member of this body, or at least as much as any other Member of this body. I thank her very much for what she has done.

The issue basically is that we have roughly \$400 billion to spend over 10 years, and the question is how we best assure that seniors get those benefits. Now, \$400 billion over 10 years may sound like a lot of money to some folks but when it is cranked out in terms of deductibles, copays, premiums and benefits, it is really a modest benefit for seniors. It is not a lot of money.

Some other programs give much more generous prescription drug benefits than is called for under this legislation. For example, under TRICARE, that is the military plan, military retirees receive substantially more benefits than are called for under this bill. The same is true for the VA. If the U.S. Government, under this legislation, were to provide the same benefits for seniors generally that the military does under TRICARE, this bill would not be \$400 billion, it would be upwards of \$800 billion to a trillion dollars, which gives one a sense of the difference.

The VA's benefits are greater. The Federal Employees Health Benefits Plan, FEHBP, provides drug benefits that are greater than called for under this bill.

I mention that so the expectations are not raised too high that this legislation is going to be the be-all and end-all, that it is going to help seniors with all their drug expenditures. It will not, but it is a first step. It is a major advancement in helping seniors get their prescription drug benefits.

There will be many bills later on in the next several years as we address ways to improve our health care delivery system generally, on how we can help improve prescription drug benefits to seniors more specifically, but we are operating under a bit of a constraint and the constraint is \$400 billion. That is what we in the Congress agreed to, \$400 billion on the Senate side for prescription drug benefits for seniors.

Under that constraint, we have to work very hard to try to achieve some balance. One goal is stability, another is efficiency. What do I mean?

Under stability, we clearly want this program to be as stable as possible so seniors know what they are getting for the premiums they will be paying. This is a voluntary program. Seniors are not

required to sign up. What we want is a stable program. We do not want a program that is changing a lot. That is unsettling to seniors.

We also want to achieve efficiencies. By that I mean lower some costs. The Medicare Program is growing exponentially. We all know that not too many years from now, when the baby boomers start to retire, we are going to face some significant challenges on how we address Medicare payments generally, which certainly will include some prescription drug benefits. We want to try to cut costs, and the idea that a balance is struck between stability and efficiency is essentially one where both private plans and the U.S. Government participate.

I strongly wish we were able to have more dollars to spend so we would have more stability and have a program that more closely resembles the military's TRICARE plan or the Federal Employees Health Benefits Plan or the Veterans' Administration plan, and even some private plans, but we do not. We are taking this steadily, a step at a time.

The Senator from Michigan has a good idea. Her idea is that in the interest of stability, as opposed to efficiency, that any senior would have the right to participate for life in the Government-sponsored plan as opposed to the private sector. We in the Finance Committee have labored mightily to try to find the right balance, and the right balance is not easy to find, I must say. We have Senators from one side of the spectrum and Senators from the other side of the spectrum bending my ear and bending the ear of the chairman. Quite often, our ears are bent so much we wonder if there is any rubber left in them. We have been talked to.

I have been talked to very much by the wonderful Senator from Michigan about her amendment. If I had my druthers, it would be something I would prefer, but we are a bit constrained. I do not know that I can support the amendment for that reason because we are trying to keep a balance.

I do want to highly commend the Senator for the great effort she has undertaken. She has clearly helped advance the ball in many ways. She will continue to advance the ball, there is no doubt in my mind. She is a great Senator for the people of the State of Michigan.

I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from Iowa.

Mr. GRASSLEY. Madam President, I rise in opposition to the amendment. I have had a chance to hear what the Senator from Montana has said about the amendment. I associate myself with his remarks. I also heard what he said about the Senator from Michigan being a fair player and offering alternatives, and I share his compliments of her and how she approaches these issues.

This is a place where we have some honest disagreements. We are going to

debate those honest disagreements, and I hope the Senator from Michigan comes out on the short end of this debate when we have a rollcall vote.

Before I make some specific statements in opposition to her amendment, I will state that the chart she has before her right now is an accurate chart, but I would like to comment on it from the standpoint of not being maybe a complete picture. I think the percentages are very accurate but we also need to remember that Medicare+Choice is not offered in all parts of the United States. For instance, in my State of Iowa, there is only 1 county out of 99—and that is Pottawattamie County, Council Bluffs county seat across from Omaha—where there are about 4,000 people out of about 350,000 seniors who belong to a Medicare+Choice plan, and I find that they like it very well. They can join in that county because they are associated with Omaha across the river in Nebraska.

Also in several major cities in California, Arizona, Texas, Florida, and New York there are several, maybe even some rural areas in those States, where they get a very high percentage. Now, how much higher than 11 percent, I do not know, but I remember back in the mid-to-late 1990s that I was able to say—whether I can still say it today, I do not know—that 40 percent of the seniors in some large cities did, in fact, choose Medicare+Choice plans. Whatever higher percentage it is in those cities, we have to realize that people are in these Medicare+Choice plans voluntarily.

I also have come in contact with many Iowans who winter in other States where they have Medicare+Choice, and they do not seem to understand why we cannot have Medicare+Choice in Iowa, and I wonder that myself. I took action in 1997 to very dramatically increase the payment to Medicare+Choices so they would come to the State of Iowa, but they still have not come.

We have increased it from \$300 per month per beneficiary up to a national floor now of \$490, and they still don't come, even considering the fact that fee for service in Iowa is closer to the \$300 per month per beneficiary. So I don't know why we can get almost 50 percent more and at least 70 percent more Medicare+Choice, yet the plans don't come to Iowa.

What I am saying to the Senator from Michigan is it is not fair to say Medicare fee for service is so well liked by seniors, as her chart would imply, that we ought to completely forget about anything but fee for service. In a lot of places people like it. A high percentage of seniors are in it. They are in it voluntarily. They can come in one year and get out the next if they want to go to the fee for service. In my State of Iowa, citizens are irritated because in Arizona they see people getting benefits through Medicare+Choice that we do not get in fee for service within the State of Iowa.

There is nothing wrong with your chart except I think it ought to be magnified to some extent so that there are a lot of people with Medicare+Choice who like it. More would choose it if it was more widely available. That is one of the advantages of our PPO section of the bill before the Senate: to give more people that opportunity. That does not necessarily mean HMO. It can be preferred provider organization or it could even be a fee for service.

Let me get back to the specifics of the amendment. The purpose of the amendment is to make the Government-run fallback plan available in every area all the time, even when the bill before us has very strict standards for the presence of private plans, and that these be met, and when they are met or provided for, no fallback is needed.

In essence, this amendment would destroy our bill's competitive incentives and replace them with a Government-controlled regime for dispensing drugs in this country. The amendment before us would also create an unlevel playing field between the Government-run plans and private plans. As a result, it would discourage the initial entry of private plans, dooming the effort to provide the drug benefit through competing private plans. This would place the drug benefit right back in the very command-and-control mentality of Government-run health care plans we ought to try to move away from. It would reinstitute Government micro-management, and it would bring about price controls.

It would ultimately put the Government into the full-time business of setting drug prices and determining what drugs are covered and which are not.

This is the opposite result of what the underlying bill is seeking to achieve with a competitive private-sector-run prescription health plan. The Government-run approach saves less than competing private plans. Private plans competing to enroll beneficiaries would achieve greater savings because at-risk plans would work harder to negotiate lower prices and work harder to offer more affordable premiums.

This fact is brought out by CBO this year, but it reaffirms everything we knew about every plan in the Senate discussed last July, including the tripartisan plan that set out the tripartisan plan savings and costing less as opposed to the Government-run plans that were offered on the other side of the aisle last summer when we debated this same issue.

CBO has indicated that a structure based on competing at-risk private plans has a higher cost management factor than Government-run plans which cannot respond quickly to market changes. The Congressional Budget Office recognizes that private plans will do a better job of managing drug costs and keeping pace with market changes.

Don't we want the seniors to have a right to choose? And they do have the

right to choose. That is what this approach is all about: not forcing something down the throats of seniors. But don't we all think we ought to have programs that respond to the market because that gives our seniors an opportunity to select products and services that are the result of the dynamics of our marketplace?

You know how long it takes Congress to make a decision. You know how long it takes a bureaucracy to make a decision. It does not serve seniors as adequately as we should be serving seniors. In fact, we know already the Government does a very poor job of reimbursing for prescription drugs because of the years of overpayment for the drugs already covered under Part B of Medicare.

Medicare has been overpaying for Part B drugs for years because of its inability to keep up with the marketplace. Taxpayers are paying more because CMS is about 2 or 3 years behind in pricing new therapies, such as new approaches in the area of prosthetics.

In fact, the bill before us includes reforms to Part B drug payments to end the overpayments Medicare is already making. But it has taken years for General Accounting Office reports and investigations by the Inspector General for Congress to act to fix this problem.

Overpayment for drugs in Part B has cost taxpayers billions of dollars and our underlying bill seeks to correct that problem. But we should learn the lessons of history and recognize that if the Government is wasting billions in overpayments for the drugs covered under Part B today, how much would be wasted by the Government if such a system were used for all prescription drugs dispensed to the seniors.

In answering that question, don't believe the assumption in my question, believe what CBO has already said about it. The Congressional Budget Office has the expertise of pricing these things and accounting for the costs. The potential waste, then, the overpayments for drugs and increased costs to the taxpayers has become astonishingly high.

Setting up a Government-run plan that undermines or eliminates private-sector competition will take choices and savings away from seniors. By pushing private plans out of the market, I believe, regardless of how well-intended the amendment by the Senator from Michigan is, it would reduce the broad array of choices that would otherwise be available to beneficiaries under the bill before the Senate. This would deny seniors the opportunity to enroll in the plan that best fits their needs by forcing these seniors into the typical one-size-fits-all model.

This would effectively deny seniors a private plan operation, which would deny them the enhanced savings achieved by the private plans. This would effectively undermine a major principle of this legislation: the right of seniors to choose. Seniors ought to have that right. They may not want to

exercise that right, but we should not assume, when there are 40-some-million seniors in America, that one program is right for all of them. We give alternatives. The right to choose is very important. The right to choose in Medicare is one of the major ways we modernize and strengthen Medicare. Medicare has become a part of the social fabric of America, like Social Security. We do not want to, in any way, affect this integral part of the social fabric of America except to give American seniors more right to choose.

The amendment before the Senate by the Senator from Michigan takes away some right to choose or destroys the dynamics of the choices we are giving to seniors.

I urge my colleagues to defeat this amendment.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Madam President, I will respond to my colleague, the chairman of the Finance Committee. First, I thank the Senator for his kind words and my esteemed ranking member from Montana, as well, for his kind words. We have different views, different perspectives on how best to provide seniors with prescription drug help, but we all share a common desire to do that and, within the confines we are operating under, to create a way to do that.

First, the Senator from Iowa, the chairman of the committee, is correct: A portion of the individuals who are in traditional Medicare are there because there are not plans available in their area. In Michigan, as I indicated in explaining the amendment, only 2 percent of the people right now in Medicare in Michigan have access to Medicare+Choice. So it is definitely true.

It is my understanding, though, that CBO has said under the new plan only 1 or 2 percent of the folks would go into managed care under this bill. If that is correct, we would not see much of a choice even if it were available.

However, the larger point is whether or not the market has worked as it relates to health care for seniors. In 1965, when Medicare was created, it came about because at that time half the seniors in the country could not find health care insurance or could not afford it. The market was not working for older Americans at that time.

I argue, also, the fact that there are no managed care plans in Iowa, northern Michigan, or other parts of the country. Again, it is a question of whether or not the market works in those circumstances. The reason Medicare came into being is because there were not health care plans in rural America, there were not health care plans available to those who needed them. We decided in one of the best decisions that has been made by the Congress—I was not there at that time—one of the wisest things that was done at that time was to say our value, as Americans, is that older Americans,

the disabled in our country, should not have to struggle to find health care. We believe health care should be available to them whether they live in a rural community, whether they live in a city or a suburb, anywhere in the United States. Our priority as Americans is to create a system that, regardless of where you live, health care would be available and affordable for older Americans and disabled.

Many say today we should be going in the exact opposite direction of expanding what we are doing to make sure everyone has the opportunity for the same health care that seniors and the disabled have in our country; that children and families, working hard every day, that individuals working two and three part-time jobs who cannot find health insurance, ought to have the ability to buy into a system of health care coverage.

There is a great need to make sure that health care is available and affordable. Medicare has done that.

I agree there are improvements to be made, such as more focus on prevention. We can certainly streamline the paperwork and bring it into the 21st century as far as technology and other options, to make the system better. From my perspective, here is a plan, unfortunately, that moves away from that stability, the dependability and affordability of Medicare.

I see my esteemed colleague from Iowa, Senator HARKIN, and I know he wants to speak. Members feel strongly about this issue. What we are doing with this amendment is the ultimate choice. It is the real choice. It is the choice the majority of seniors have already made, and it is the choice they want. Under the underlying bill, the only way they could get to the place to choose what they want is if private insurance plans were not available in their area. The plan goes through all kinds of changes to try and make that available, even if it costs more.

Ask any small business, any large business in this country today, how fast their private insurance premiums are going up. We have seen small business premiums double in 5 years. We have seen Medicare going up about 5 percent. We see private sector going up 15, 20, 25, 30 percent a year. This says rather than having a plan that goes up 5 percent a year, we are going to design this so it goes up 15 or 20 percent a year.

That does not make sense. In all honesty, the only group this makes sense for are the pharmaceutical companies who do not want folks in one place to be able to bargain and negotiate lower prices, which is what Medicare would be able to do—negotiate lower prices.

For all who want to get this right for our seniors, I urge my colleagues to join in creating real choice for our seniors. Give them the opportunity for the choice they want. If, in fact, someone chooses to go into managed care, an HMO, PPO, or other kinds of private plans, they should have that choice, as

well. This amendment allows them to do that.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, as the cosponsor of the Stabenow amendment, I add my strong support for the amendment offered by my distinguished colleague from Michigan.

Senator STABENOW has it right. She understands what is happening. Senator STABENOW has time and time again come to the floor to point out we need to give seniors more choices rather than fewer choices. That is what we are doing with this amendment.

The bill we are considering in the Senate this week, S. 1, has a number of flaws despite its good intentions. Its prescription drug benefit for seniors is far from comprehensive. There is a significant coverage gap. Premiums are not fixed. Many of the copays are too high. The bill does not contain the actual costs of prescription drugs. Although the generics amendment, which I assume will be added to the bill, which will certainly help in that regard, the bill does not go into effect until 2006; interestingly enough, just to get us by the 2004 election.

I have a number of concerns. I plan to speak about all of these as we proceed on this bill this week. One of the most significant flaws in this bill is addressed by this amendment offered by Senator STABENOW; that is, this bill requires seniors obtain the prescription drug benefit through private insurance unless there are not two such private insurance plans in their area. In other words, a prescription drug benefit through Medicare is only available as a so-called fallback.

In other words, if you are a senior in, let us say, a rural State where there are no private HMOs—speaking about my State of Iowa, we don't have one Medicare-based HMO in the State of Iowa. Let us say you are in an area and you have two private plans. You don't have a choice other than those two. That is all you have. You have those two. If you are in a State where there are not two plans, then you can get Medicare. Let us talk about this. It is only a fallback position. If the two plans aren't there, then you can get it through Medicare.

What Senator STABENOW's amendment says is that we want a prescription drug benefit through Medicare that would be available to all seniors at all times so they can have a real choice. Under this amendment, this is how it would change the bill.

You are in an area and you have two private plans. You could also have Medicare. Now you have one of three choices. Under the bill here, you have one of two choices. We are expanding the choices. We are saying you can go with private plan A, private plan B, or Medicare. You have the choice. If private plans are so desirable and they are so good, then let them compete against a Medicare benefit. Let us see which one a senior chooses.

I found the arguments propounded by my friend and colleague from my own State of Iowa Orwellian at best. The chairman of the committee was talking about choices. We want to give seniors choices. If a senior has one of two choices, or one of three choices, which one gives the senior more choices? The chairman of the committee said the first one that offers two plans gives them more choices. That is Orwellian. It is Orwellian-speak that somehow two choices are more than three choices. Go figure.

To me, this is the key issue that needs to be fixed in this bill. I am glad it is the first amendment because it is vital. I think it represents the fundamental difference between many on our side and many on the Republican side on this bill.

I want to be very clear. I am not against a free market. I am not against the private sector or private health insurance plans. But the reality is that the private sector by its very nature leaves certain groups of people behind, especially in the health care area.

Let us be honest about it. People with disabilities are not a profitable group. You have a disability. Try getting insurance. Try it. There is no money to be made there. People with mental illnesses are not a profitable group. We have been trying for some time to get mental health parity. We still don't have it because the private sector understands they can't make money.

Guess what other group is not profitable? Senior citizens are not profitable. They use more health care as they get older. So they are not profitable.

If you look back in history, that is why we established Medicare in the first place in the 1960s—to care for those people who were left behind by the private sector.

I remember as though it were yesterday when my father was in his later years and had health care problems. In the 1950s my father was then in his early seventies. He had been quite disabled from working for over 20 years in coal mines. He had "miners lung," as they called it then. Later they called it "black lung." He had had some accidents. He was now in his late sixties. He was in his early seventies in the 1950s. His health was in bad shape. He was on Social Security. That is all he had. He had no life savings. He had no dividends. He owned no stock. My father only went to the 8th grade. He worked most of his life in the coal mines. After that, he worked as a handyman. All he owned was a small house on 1 acre of land. That is all he had. Thank God he worked enough to pay into Social Security to get a Social Security benefit. But he had no health care insurance. He had no outside sources of income. He had some young kids, me being one of them. We had no outside source of income at all. My father's income in the 1950s on an annual basis was probably around about—I would be surprised if it was over \$2,000

or maybe \$2,500 a year at the most. He couldn't get health insurance.

There was no one who would sell my father health insurance, even if we could have afforded it. Later on, when a couple of his kids got out of college and we looked around to try to see if we could get some, no one would cover him. He was now in his midseventies and had black lung disease. He had a few other problems. Try to find an insurance program. There were health insurance programs at that time. There were a lot of health insurance programs that covered a lot of workers at that time through their employment but they were not about to cover my father. That would not have been profitable.

I remember when Medicare came in. My father got his Medicare card. Now he could go to the doctor and go to the hospital.

There are those of us who lived through this and saw our parents denied health care coverage because they couldn't afford a private health care plan because the private health care plans left them behind. We look at this bill and say: Wait a minute. You are saying you are going to have these two private plans out there but you are not going to have a Medicare choice?

We experimented with private health care and HMOs. Guess what happened. Seniors all over the country were dumped by plans. They had a plan. They signed up. As soon as the plan saw they weren't making money, they said: We are out of town. So seniors were dumped. We didn't have a law that said you had to cover them. They just walked away from it.

That is what is going to happen with this bill, too. Obviously, they can do it on an annual basis. That is another point of this bill that is going to get highlighted. A plan could be in effect and they find out after a year they are not making enough money. Bang, they walk away. Then maybe another plan will come in. Oh, well. Maybe a senior can sign up for that. What is the coverage, or the copay, or what is the deductible? It may be different.

For years, Republicans have not so subtly wanted to privatize Medicare. There were public comments such as then-Speaker Newt Gingrich who said about Medicare that he wanted to "let it wither on the vine."

I think when you read those statements and the statements by the third ranking Republican in the Senate who said that the basic Medicare benefit basically needs to be done away with, you get an insight into the long-term goal of those on that side.

What they state is their support for including the private sector here to take advantage of the efficiency by the experience and the virtues of private competition. All well and good. I am all for competition and efficiency. But what happens is that this bill now before us relies on the participation of private plans to deliver this drug benefit to our seniors. But you have to set the rhetoric aside.

The current structure of this bill before us invests unwisely in private health plans to provide the drug benefit for seniors, and it restricts their choice. It restricts it. As I said, the Senator from Iowa, the chairman of the committee, spoke about giving seniors choices. That is exactly what the Stabenow amendment does. If they do not want to be in Medicare, they can go out and get a private plan. But under the bill before us, if they do not want to be in a private plan and want to stay in Medicare, they cannot do it.

Now, again, for some reason I am having trouble understanding this argument made by the chairman of the committee that somehow having two choices gives you more choices than having three choices. Someone has to really explain this to me because that is what the Stabenow amendment does. It gives you three choices: Medicare, plan A, plan B. The bill before us gives you two choices: plan A or plan B.

Now, again, this is especially bad for seniors in rural States where private plans have shown no interest in participating in the Medicare program. Now, again, the scheme in this bill of having the private plans only—if there was some history to back this up, and the chairman of the committee talked about history. Well, OK, let's look at the history. We know from history the administrative costs in Medicare are much lower than in private health plans—2 to 3 percent a year compared to 15 percent in the private health care plans. We know that. That is fact. That is data.

We also know that over the past 30 years Medicare spending has grown at a slower rate than private health care spending; about 9.6 percent for Medicare, over 11 percent for private health care plans. We know that. It is factual. Yet ignoring this history, in the plan before us, this administration and the Republican leadership in the Senate insist on relying almost solely on private plans to provide this drug benefit to our seniors.

As I said, the bill before us might be reasonable if we had some past history to back up the fact that the private health care plans were the most efficient. They want to talk about efficiency. The facts show that administrative costs are about one-fifth—one-fifth—as much in Medicare as in private plans, 2 to 3 percent compared to 15 percent. So efficiency? Obviously, Medicare is more efficient.

And the cost, well, as I said, over the last 30 years Medicare has grown at a slower rate than private health plan spending. So which costs more, Medicare or private health care plans? Well, we have the facts. We have the data. This cannot be ignored.

The only way you can ignore this data and these facts is if your ideology trumps experience. If you have an ideology that says we are going to set up a system that will ensure that Medicare sometime in the future fails, I guess you could ignore facts, you could

ignore the history. And that is really what this is all about, folks.

The result of all this private plan investment means there is less money available to actually help seniors get the drugs they need. It is estimated that the underlying bill will actually pay private insurance companies over \$25 billion just to participate. Boy, talk about a sweetheart deal.

OK, let me get it straight now. We want only two private plans out there in a region for seniors. The bill will not let Medicare compete. That is what the Stabenow amendment does for us, it allows Medicare to compete. The bill will not. So you have two private plans out there. Because why? "They are more efficient. They have more experience," et cetera, et cetera. "They will have competition, and the competition will keep the price down." Then why are we giving them \$25 billion in subsidies to get them into the program? You would think they would be knocking the doors of the Senate down rushing to get in on this.

Let me proffer a question. What if we took out the subsidies to the private insurance plans? How many would come into this program? Zero. No, we are going to give them \$25 billion. What if we took that \$25 billion and we put it into a prescription drug benefit? Well, we could cut down what? We could cut down the deductible, maybe. We could cut down the copays. We could close the coverage gap—all of which would help our seniors. No, no, no. We are going to take \$25 billion and we are going to help the private insurance companies. We are going to coax them. I have a different word. We are going to bribe them. We are going to bribe them with \$25 billion of money to come in here.

Talk about efficiency. Boy, isn't the private sector grand. Isn't competition wonderful when the Government comes in with your taxpayers' dollars and gives them \$25 billion so they can offer some kind of a prescription drug plan.

I mentioned just a minute ago about how in the past private plans have come into existence. Seniors join them, and then the plans close down, leaving the seniors holding the bag. That is the history. That is the data. That is what has happened. Because of the structure of this plan, seniors could be forced to switch plans and drugs on a yearly basis—yearly—as private plans may join and then pull out of the markets.

So you have these two plans out there. Your grandparents, your parents, join plan B because it looks good for them, and it turns out maybe the first year it is OK for them, but the plan they joined finds they are not making enough money. Guess what. At the end of the year they walk away.

Now, what do your grandma and grandpa do then? Well, they can go to maybe plan A, or maybe another plan will come in, have a different copay, different deductible, different this, different that. And I will tell you, if you think your health plan today is con-

fusing—and it is. I look at my health care plan every year when the open season comes around and I try to make heads or tails of it. I was trained as a lawyer. I may not be a very good one, but I was trained as a lawyer, and reading these things is confusing, even for someone trained. Put these plans out there for the average senior citizen to read every year of who gives what, what is the benefit—total confusion.

Then what happens? Well, people get confused. They get upset with the program. Seniors talk among themselves at their various groups and clubs, and they find out that Mrs. Jones over here, while she has an income of \$14,640 a year—guess what—her deductible and her copays are up here, they are high. Mrs. Smith, her friend and neighbor, who comes to the same club, her income is \$14,639—\$1 less—and she gets all hers free. Think about that. Think about what this is going to mean to the elderly out there when they see: Wait a minute, my neighbor, my friend, they get a few dollars more a year than I do. They pay. I get a few dollars less. I don't have to pay anything.

What is that going to lead to? Not only to confusion, it is going to lead to anger, and it is going to lead ultimately to seniors saying that this whole system has to be changed. And that is the end result of what the Republicans want to do with this bill; that is, to strike a dagger to the heart of Medicare. Now they can't go after the heart right now, so you cut a few veins. You take a leg here and a leg there and an arm here and an arm there, and pretty soon Medicare is done for.

That is why this amendment by Senator STABENOW is so important. It follows a simple and reasonable philosophy that says seniors who want to stay in traditional Medicare ought to have that choice. We are not forcing them. Senator STABENOW is not forcing any senior to stay in any plan. She is simply providing them the choice.

Again, as the chairman of the committee said earlier, as the President has said, they extoll the virtues of giving seniors more choices. I say yes, let's give them more choices. This amendment does that by doing two things. It gives seniors the option of staying in traditional Medicare for all of their health care needs including prescription drugs. They have that choice. They don't have to if they don't want to. And as Senator STABENOW has shown time and time again, 11 percent of the seniors have said no, they don't want to stay in Medicare. Fine, if they want to go somewhere else, that is their privilege. Her amendment would not change that whatsoever.

But the second thing the Stabenow amendment does is it guarantees our seniors, especially those who live in rural areas where private plans are less likely to participate, a reliable and consistent option that will never leave them without coverage.

Throughout this debate, we have heard and will continue to hear our

friends on the other side, the Republicans, talk about how great private plans are, how they will control costs through competition. I just cited some statistics that show that historically this has not been true. The Stabenow amendment will make sure that every senior in every State has access to a consistent benefit and the option of staying in the Medicare Program.

I would think—maybe I am naive; I hope not—that if the chairman of the committee and the Republicans really wanted to give choices to seniors, they would welcome this amendment. If you listen to our friends on the Republican side and trust them, you will believe the private plans will provide a better benefit at a better price to seniors. If that is the case, what are they afraid of?

If the Republicans truly believe the private plans will provide a better benefit at a better price to seniors, why are they so afraid of letting seniors have Medicare as an option then? Because obviously they would pick the private plan because it would be better than Medicare. So what are they afraid of? Why would they not want this amendment? Because, all rhetoric aside, the Republicans want to restrict choice. They want to force seniors into private health care plans—force them—and only if there are not two plans available, then you get this fallback into Medicare. If it is good enough as a fallback, why not let it compete upfront?

I may have an amendment on this later in the week, but if these private plans are going to be so good and they are so good at competition and efficiency and so good at keeping prices down, why do we have to give them \$25 billion in subsidies? Let them go out there on their own. That is the private market. I don't think they need the subsidies if they are truly going to provide this kind of a benefit. Again, I am not arguing it now. I am saying that may come along later.

The Stabenow amendment provides seniors with three choices. The bill provides them with two choices. So this amendment offers them more choices than the underlying bill does. If what the Republicans want are more choices, this is it. They should support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Madam President, on behalf of the leadership, I ask unanimous consent that following my remarks, Senator GRAHAM of Florida be recognized to speak for up to 10 minutes on the Stabenow amendment.

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

TENTH CIRCUIT COURT OF APPEALS DECISION

Mr. DOMENICI. Madam President, I thank Senator GRAHAM for allowing me to speak on a matter of utmost importance to my State. That accounts for the consent that he would follow me. He was supposed to speak next.

I come to the floor to discuss a situation of grave concern in my State of New Mexico. On June 12, the Tenth Circuit Court of Appeals issued an opinion that puts the fate of a small endangered fish called the silvery minnow ahead of the interests of the people of New Mexico. This ruling has far-reaching implications for all Americans. It essentially favors fish over people.

This ruling requires that the Bureau of Reclamation reassess its contractual obligations to provide water to the cities of Albuquerque, Santa Fe, and others—even water resulting from interbasin transfers. The two judges issuing the majority opinion conclude that under the Endangered Species Act, the water needs of the silvery minnow come before the water needs of the people of my State.

This far-reaching opinion essentially says that the Endangered Species Act can be used to artificially create a drought. That is precisely what is going to happen if the Bureau of Reclamation deprives cities, farms, and Indian reservations in my State of the water they desperately need. The ruling says the Endangered Species Act can preempt anything and everything, essentially.

This opinion creates a new Federal right for endangered species. It effectively invalidates preexisting contracts and orders the importation of water from another basin in violation of New Mexico law that allows only for municipal use. In essence, it says even that water must be used for the fish. The water resulting from the interbasin transfer was never part of the ecosystem or the stream basin. It was brought in for other purposes. Under the court's theory, no city, county, State, or agricultural community can reasonably expect a permanent water supply.

This is not what Congress intended when we passed the Endangered Species Act. This is not what I intended when I voted for the law. The concurring opinion of Judge Porfilio says that the Endangered Species Act can undermine any contract with the Federal Government for the supply of water resources if bureaucrats determine that an endangered fish or threatened species needs the water. As we saw with Klamath Falls 2 years ago, bureaucrats are often wrong in these affairs. But no matter, according to the court, what Federal bureaucrats mandate in the name of ESA must be so, regardless of the devastating consequences.

Did any of us who voted for the Endangered Species Act believe we were amending all Federal laws and contracts at the time of its passage? I certainly did not. Has anyone who has contracted with the Federal Government for a timber lease, mineral lease, for water, or for use of Federal facilities included a clause that says such contract will not be amended by action under the ESA? Because, according to this ruling, if one didn't, the contract won't stand if a bureaucrat somehow or

somewhere decides that a fly, a fish, or rodent needs that resource.

This decision cannot be allowed to stand. It threatens all Federal contracts. It undermines the financial integrity of the United States of America and all of those with whom she contracts.

This opinion will be devastating for western water users at a time of growing crisis in the West. Currently, after years of drought, agriculture, States, cities, and counties are struggling to meet their water needs now and in the future. There simply isn't enough water to go around. Members of Congress have been deeply involved in trying to resolve this growing crisis. Now comes the Tenth Circuit Court of Appeals with its announcement that the ESA preempts 75 years of existing water law, all existing contracts, and the needs of the burgeoning western population. This ruling hobbles us in our efforts to address the western water crisis.

Judge Kelly, in his dissent, rightly characterizes the ESA as a Frankenstein. Despite good intentions, this law has become a monster.

Congress never meant for this to happen. Yet, for years, we have stood by as our own law has wreaked havoc—oftentimes needlessly—in the cooperative relationship of man and nature.

I believe there is a better way. I believe we can amend this law to better protect struggling species, while still respecting the authority of this Government, States, localities, and Indian tribes. I believe we can amend this law to better protect struggling species, while still allowing people access to the resources we need to survive.

Critics have rightly pointed out that since the passage of the ESA, the number of threatened and endangered species has increased exponentially. There are now more than 1,100 species on that list. Only a handful have recovered since the passage of the ESA. Most of them, like the bald eagle, recovered because we banned the use of DDT. I have not seen evidence of any species that recovered because of abrogated water rights, which is the principal issue discussed by this Senator regarding this opinion.

As this law is now written and interpreted by the courts, we are failing our struggling species. We are also failing our citizens who look to us, State, and local leaders, for access to the resources they need to live.

This ruling says we cannot even guarantee them the very water they need for survival, sanitation, and food. In fact, it says we cannot do that by importing water into a river basin in which the fish lived before the importation. This decision says that even imported water for local use can and must be allocated for these fish. Government cannot function under such prescribed chaos.

Madam President, we must amend this law. I don't know when it will happen, but I will ask this Senate to address this law and the far-reaching implications of this decision. I will have that ready soon so that the first bill that goes through here can carry it along to fruition.

Certainty is the bedrock of western water law. That certainty is critical for our people and our country and our economy and, yes, our environment, including the endangered species. Certainty is a must for endangered species also. The court, however, chose to abandon collaborative efforts and the 2003 biological opinion and directly threaten every interstate compact in America, established adjudication, and the intent of Congress.

These rights are all out the window by virtue of this 2-to-1 opinion. A request for a rehearing en banc will be made to the Tenth Circuit and, obviously, the State of New Mexico must take it to the Supreme Court, if necessary. But I am going to look to the Senate—at least for New Mexico and what I have described here today—for a way to fix it by statutory prescription. I will be looking for the help of Senators within the next month or two on one of the bills that moves its way through here.

I yield the floor.

AMENDMENT NO. 931

Mr. BAUCUS. Madam President, if I am not mistaken, the pending amendment is the one offered by the Senator from Michigan. I see the Senator from Florida, Senator GRAHAM, who would like to address the Senate.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. GRAHAM of Florida. Madam President, I rise in strong support of the amendment offered by the Senator from Michigan. We are about to undertake a massive social experiment. We are about to do it with the 39 million older Americans, including some of the most vulnerable and frail of our fellow citizens. Why do I say this is a massive social experiment? Because there is no example in America of a freestanding drug-only insurance policy as the means to gain access to prescription drugs.

There are some very fundamental reasons why we don't do that in the Federal Employees Health Benefit Program, and why even the pharmaceutical industry doesn't do it in distributing drugs to its employees. There are two basic reasons why this is a first-of-a-kind social experiment. One is this is not an insurable risk. The example that has been frequently used is the one of fire insurance. If you are going to purchase fire insurance, you buy it on the whole house, from the bedroom to the living room, to the garage, to the kitchen. If you were to go to your insurance company and say I don't want to insure the whole house, I only want to insure the kitchen, the answer would be we won't sell you such a policy because the kitchen is the

most vulnerable part of the house to actually have a fire.

This is a similar proposition. Prescription drugs are the fastest growing part of the health care budget. Insurance companies don't want to sell a prescription-drug-only freestanding policy. That is seen in the structure of this bill. Essentially, although the statement is made that we are going to get better prices because of competition and the willingness of insurance agencies to assume the risk, the Federal Government is assuming virtually all the risk under this plan. Therefore, all of the expectations and representations that we are going to have competition through that lower cost is a mirage.

The second reason is the fact that within health care, there are tradeoffs. As an example, just a few years ago the standard way of dealing with ulcers was surgery. Today there is almost no ulcer surgery; the standard treatment is through prescription drugs.

What is the relevance of that? If you are only providing prescription drugs, if you had a freestanding prescription drug only policy, all you would have is the additional cost of prescription drugs. If you are insuring the whole body, you get the savings of avoiding surgery while you get the additional cost of providing the prescription drugs.

Those are just two of the reasons there is no other example of what we are about to impose on 39 million old, many very sick, many very frail, Americans as a social experiment. If we were going to do this, I think what we ought to do is say we are going to change the Federal health insurance policy starting now and let us all be the experiment to find out whether such a freestanding prescription drug policy will work.

We represent a much more diverse population—Federal employees. Many of us are younger, healthier than the Medicare population. We would be a more appropriate guinea pig for this experimentation than to focus this on the oldest and, in many cases, the most vulnerable of our people.

A second concern I have about this approach is that it denies choice. Under the structure of this bill, once the elderly have made two choices, then they will not have any choice at all as it relates to prescription drugs.

The first choice they make is the choice that they are making today and have made for many years in the past: Will I get my total health care coverage through traditional Medicare, the fee-for-service plan, or will I get it through some form of a managed care plan?

The jury has come in and rendered its verdict on that issue. Over 85 percent of America's elderly have decided they want to get their health care through the traditional fee for service. The basic reason they want fee for service is that is the true access to choice. Under fee for service, they can

decide what doctor, what hospital they wish to use. Under the various managed care plans, they frequently are restricted in their choice, and they have to use a gatekeeper in order to get to what choices are available.

We have had a big debate in this Chamber, a debate I anticipate we will return to, and that is over the standards of managed care. That debate was sparked because so many people have had a negative experience with managed care, where services were denied or where they did not have access to the physician they wanted for their particular needs.

This whole debate about whether there should be some Federal standards for HMOs is because of the actual real-life human experience of many Americans, including older Americans, as to how these managed care systems work.

After the Americans have made the judgment as to which plan they wish to be in, then they will make a second judgment, and that is, under this prescription drug plan, do they want to take advantage of it? It is yes or no as to whether they will participate in the prescription drug plan.

Once they have decided, yes, I wish to participate, then they lose their choices. If they are in the traditional care plan and if there are not two or more standalone prescription drug plans, then they will be forced to get their prescription drugs through the social experiment with a freestanding prescription drug plan. If there is only one plan where they live, they will be denied access to that single plan and they will have to get their drugs through traditional Medicare. I think that is a denial of the fundamental option and choice which has been a key part of the success of Medicare.

I also think denial of choice could well be the torpedo which will sink prescription drugs. We learned a lesson about 15 years ago when we passed something called catastrophic care which the Congress thought would be received by the elderly with roses and flowers and applause. In fact, it ended up being received by the chairman of the House Ways and Means Committee having his car turned upside down, there was so much objection to that plan.

I think we had better keep our cars in the garage after we pass this because we may experience the same thing, and this issue will be one of the reasons, in my judgment, that there will be less elderly participation in the prescription drugs and an increased likelihood that there will be a sufficient revolt that we will be forced, as were our predecessors, to repeal what we thought was going to be a very popular plan.

This prescription drug architecture only works if a very high percentage of the elderly sign up to participate. If the only ones who sign up are those who are already sick and using high levels of prescription drugs, this plan will crater as being actuarially unsustainable. If it is to attract

enough of the elderly who are not sick and do not have high drug bills, who will see this as a true insurance policy—that is, that they are purchasing this plan not just based on their current prescription drug costs but because they believe they may someday become ill, sicker than they are today, and get into this category of high cost—we must be able to attract that group of the elderly in order to make this plan sustainable.

I think one of the reasons the relatively healthy elderly will resist joining this is precisely this issue of the denial of choice. If I am an elderly person and I live in a rural area of Florida where only one prescription drug plan is available, why shouldn't I be able to elect that one prescription drug plan or traditional Medicare? If, on the other hand, I am in an urban area where there are 20 freestanding plans, although I think this is a highly unlikely prospect, why shouldn't I be allowed to elect one of the prescription drug plans or traditional Medicare?

Why? What is the rationale of us denying the elderly that important choice when there is no evidence that the standalone plans are going to actually save money? This bill itself is the best evidence of its unlikelihood of doing so since the Federal Government is picking up most of the risk that the standalone plans will, of their necessity, entail and while we are denying choice to elderly as to which of the various options they want to utilize.

I cannot conceive of why we are saying to America's elderly that they will be denied the choice how they want to get their prescription drugs, particularly when they have spoken so overwhelmingly of their desire to stay in traditional fee-for-service Medicare for the rest of their benefits.

So for those who favor the approach we are taking, they ought to be the strongest voices for the Stabenow amendment because it is one of the key steps in assuring that this plan will be positively received by Medicare beneficiaries and will actually work once it is in place.

I urge all of my colleagues, those who favor the basic principles of this plan and those who have reservations, to vote for this amendment because it is fundamental to achieving the results that are being sought, a broadly participated in prescription drug plan which is sufficiently attractive, including attractive through choice, for America's older citizens.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from Nevada.

Mr. REID. Parliamentary inquiry. Is there any consent now in effect dealing with who speaks next on this amendment?

The PRESIDING OFFICER. There is none.

Mr. REID. The two managers asked if Senator REED from Rhode Island could speak for up to 5 minutes—is that right?

Mr. REED. Ten.

Mr. REID. Ten minutes. The Senator from Georgia only has 5 minutes to speak generally on the bill. So I am wondering if the Senator from Rhode Island would allow him to speak for 5 minutes?

Mr. REED. I would be happy to.

Mr. REID. Is that right?

Mr. CHAMBLISS. That is correct.

Mr. REID. I ask unanimous consent that the Senator from Georgia be recognized for 5 minutes to speak on the bill generally and following that the Senator from Rhode Island be recognized for 10 minutes to speak on the amendment.

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

The Senator from Georgia.

Mr. CHAMBLISS. Mr. President, I thank the Senator from Nevada and my friend Senator REED for being gracious enough to let me speak on this bill.

All of us who have served in this body over the past several years, whether it is during our campaigns, going back home for town halls, or visiting home over the weekends, have talked about the need for a prescription drug benefit within Medicare. We all agree on that. I am very pleased that this week, as well as all of next week, we will be debating this issue regarding the inclusion of a prescription drug benefit within Medicare and the overall improvement of Medicare.

I am also very pleased that the particular bill that came out of the committee has certain options available for seniors in it. The one thing we tend to do from a legislative perspective is to put mandates and dictates on people, particularly when dealing with health care. This particular bill does not do that. There are significant options in this bill that Medicare beneficiaries are going to have with respect to a prescription drug benefit. I think having these options in place is going to put competition in place within Medicare and allow the marketplace to work.

There are senior citizens today that we all refer to, and now I would like to concentrate on. I am talking about those low-income senior citizens who have high drug costs that need to be taken care of. While I remain positive that we are developing a bill—and there are a lot of positive things within this bill—I am very concerned that we are reaching beyond what most of us in this body have talked about over the last several years with respect to a prescription drug benefit; We are going way above and beyond providing that benefit just for those low-income, high-monthly-drug-cost individuals who so desperately need this benefit.

The reason I am so concerned is that from a fiscally responsible standpoint, it is incumbent on us, as Members of this body and as members of the House, that we do not overreach and put a burden on the young people in this country. I don't want them coming back to us one day and saying, "What in the

world did you folks do to us in 2003 by imposing such a heavy financial burden on Medicare? Because of this prescription drug benefit, Medicare cannot remain solvent without increasing payments going into Medicare."

I have strong concerns that we are overreaching with this bill. That is why I am so pleased the Senator from Nebraska, the Presiding Officer today, and the Senator from Nevada, Senator ENSIGN, who have studied this issue and have developed a substitute which may be offered as an amendment. I look forward to having a healthy debate working with their language in addition to the base bill coming out of committee. It is my sincere hope that we can find the right answers, and at the same time, continue to serve and provide a benefit to those people who so desperately need it.

There is another issue that I want to make sure we are very deliberate about and that we cover, and that is the issue regarding the ability of our pharmacists, particularly in rural areas, to participate in this program. We cannot afford to have a one-size-fits-all benefit that allows individuals to go straight to the manufacturing source for their benefits under this plan. These pharmacists, particularly in rural areas, deal with individual patients and customers on a daily basis. They provide a service that not only benefits the patient and the customer but benefits Medicare. Pharmacists give advice and counsel regarding the drugs that have been prescribed for them, and I think without question will save millions of dollars in future years in this program within Medicare.

Lastly, I could not stand up and talk about a prescription drug benefit without recognizing that our drug companies over the years—and I happened to be sitting in the chair yesterday when Senator DORGAN was talking about this, and Senator DORGAN is exactly right—have stepped up to serve seniors by providing significant amounts of drugs to low-income individuals who simply could not afford to buy those drugs. These companies offer monetary discounts on large quantities of drugs to seniors involved in their plans. One of those companies, Pfizer, happened to be in my office today reiterated exactly what they have done. This is a very positive thing we should all remember when we are talking about our drug companies.

As we move forward with this bill for the next 2 weeks, I remain very cautious about where we are going to be at the end of the day. We do have to make sure that we have a healthy debate in light of the fact that we do have to provide a prescription drug benefit. We know a bill is going to pass, but we certainly need to send the right bill into conference with the House, so that when it comes out of conference it benefits those folks who need it most, those low-income individuals with enormous monthly drug bills. We should be able to look these young

pages in the eye and say we did not saddle them with a burden that will be unaffordable years from now.

So I thank the Senator from Nevada for letting me interrupt and the Senator from Rhode Island for letting me come in and give my speech now. I look forward to the debate over the next 10 days as we conclude this at the end of next week.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

AMENDMENT NO. 931

Mr. REED. Mr. President, I rise in strong support of the Stabenow amendment. I believe the Senator from Michigan has done exactly what is right, proper, and wise to do, which is to provide for a permanent fallback prescription drug benefit for our seniors in the context of this new Part D drug program. Indeed, out of the 650-plus page of this bill, the proposal by the Senator from Michigan is the one that most closely resembles what is familiar to seniors with regard to the current Medicare Program. It is an important issue.

According to the Congressional Budget Office, roughly 32 percent of Medicare beneficiaries enrolled in the proposed new Part D program would receive their drug coverage through the fallback plan, at least during the initial implementation of the program, so a significant number of seniors we already know will participate in these fallback plans.

The reason is because under the existing language of the bill, if two private companies are not prepared to offer pharmaceutical benefits in a particular region, Medicare must have a fallback program for seniors. That makes entirely good sense. The problem is, if and when there are two companies, this fallback provision evaporates. It goes away. What this will lead to is instability and a circumscribed choice for seniors.

We can just imagine a senior who enters the fallback program may spend 1, 2, 3, or 4 years there, is happy with the program, satisfied with the benefits, and suddenly they are told, no, this program is going away because there are now two competitors in the marketplace. It does not make sense. It circumscribes choice and it creates instability and uncertainty in a program that should be full of stability, certainty, and choice. I hope we can adopt this amendment to ensure that the Medicare fallback program is a permanent part of the Part D program.

Let me suggest something else. When we think of the dynamics of this proposed program, two pharmaceutical beneficiary management companies come into a particular region knowing full well if one decides to go, then Medicare would have to reconstitute this fallback program—expensive—probably on short notice. That is tremendous leverage for other PBMs in the market to go back to the Medicare program and say, wait a second, we are

leaving unless you provide additional incentives, additional compensation, additional risk sharing.

That is a leverage point that I think will be exploited by businesses. It is a fair point to exploit. They can vote with their feet. They can leave the region. That is tremendous power to put in the hands of any one plan—it is not the two; anyone could decide to go—and suddenly you have to constitute the standby.

If there is a permanent fallback program, that leverage does not exist. Automatically, the senior would choose or not choose to get their benefits from the fallback program. That is another important aspect.

We also understand these managed care programs and pharmaceutical benefit managers operate, obviously, to make a profit. They are prepared and capable of leaving on short notice if, in fact, they believe they are not realizing a profit.

We have seen this in my home State of Rhode Island, a state with a significant penetration of Medicare managed care. Thirty percent of beneficiaries in Medicare in my State are enrolled in a managed care plan. There used to be several managed care plans, but most have left the market, leaving essentially one insurance company providing these managed care benefits. When the other plans departed, we saw increases in costs to seniors and less generous terms offered by the surviving companies. Why? Simple. Competition slacked off; they did not have to be as aggressive competing for seniors. That likelihood could happen in this case.

Again, that is a strong argument for the Stabenow amendment, to have at least one plan that will be there, with permanent, defined benefits that are not likely to change as other competitors drop out of the market. That is another selling point, a strong selling point, for the Stabenow plan.

I believe this amendment is very important. It will go a long way to assuring seniors they are not part of some arbitrary experiment in the marketplace, that there will be at least one plan that is always there, that the benefits are well defined, and that plan will be an important aspect of making sure there is market discipline as well as consumer choice for seniors.

Some people might say: We cannot do this because we have a cap of \$400 billion over 10 years that limits us. That is an arbitrary limit, obviously. In fact, it seems to me it is a limit that is not justified, given the generous tax cuts we have already provided to so many wealthy Americans as opposed to those likely recipients of this package. This arbitrary cap should not limit us from creating a program that we hope will not only endure for a long time but will be efficient, effective, and attractive to seniors.

I believe if we pass the Stabenow amendment, we are going to make this program much more attractive to sen-

iors, give them confidence they have at least one choice through the standby plan, that will not leave the marketplace, that will not change benefits as competitive forces change, that will be something they can count on. As well as receiving pharmaceutical benefits, I think seniors are asking for something else, and that is confidence that their benefits will endure and not be ephemeral.

As a result, I urge my colleagues to support the Stabenow amendment.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Michigan.

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

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

Ms. STABENOW. Mr. President, I appreciate my colleagues coming to the floor in support of my amendment. I take a moment to reiterate what we are doing in this amendment.

We are indicating in this amendment we want to make sure every senior has the choice of traditional Medicare for prescription drugs as well as a choice of HMOs or PPOs or other private sector plans. We are talking about seniors wanting to have choice or the desire to give seniors choice.

The majority of seniors, as a matter of fact, like traditional Medicare. It is very clear. They either have chosen traditional Medicare or do not have any private options, and 89 percent of our seniors fall in that category. The majority have chosen Medicare or may live in a rural area where they do not have the choice of a private plan but they are in Medicare and they have their coverage, they can choose their doctor, they can live anywhere within their State or anywhere in the country and know the cost will be the same. It is dependable; it is available to them.

That is what we are trying to do, guarantee seniors will be able to continue to have that choice along with new options for those who live in an area where there is a managed care plan and they choose to go into an HMO or PPO, that would be absolutely available to them. If they choose another private insurance plan, assuming there are those available to them, fine, that is certainly an option that we all agree should be available to our seniors.

The question is whether we will shut off the choice the majority of seniors have already selected, the one they say they want. With all of the talk about choices, what I hear from folks is not: Please give me more insurance plans to wade through or to figure out how to get health care; please give me more insurance bureaucracy to wade through each day. Seniors say: Update Medicare and cover prescription drugs.

It is simple. They want their traditional Medicare, choose their own doctor, choose their own pharmacy, to be able to make their own choices and to have them available regardless of where they are in the country, but they want to make sure they have prescription drugs as well.

We know if health care in 1965 were like it is now, prescription drugs would have automatically been covered. We know that. We also know in 1965, as I indicated earlier, Medicare came into being essentially because of a failure in the private market. That is not a criticism; it is a reality that covering older Americans certainly is more costly as we use more health care. As we get up in age, we find we use more health care, we use more prescription drugs. There are fewer carriers wanting to cover. Certainly, way back in 1965, that was the case when half the seniors in the country could not find a private insurance plan or could not afford a private insurance plan available.

Medicare came into being in order to make sure that health care was available for older Americans and for the disabled in our country. It was a value statement about who we are and what we think is important. It was an important value statement just as Social Security coming into being was a value statement about the fact we wanted to make sure there was a basic amount of money for everyone to know there is a certain amount of financial support available to them as they get older, as they retire. It is a value statement. Medicare and Social Security have both been great American success stories.

We are now at a point where medicine has changed, the delivery system, the way we provide care. Most of us go to the doctor's office and walk out with at least one prescription. We have the opportunity to take medicine to keep us well, to manage our high blood pressure, cholesterol, or other issues that allow us to remain healthy and remain out of the hospital. These are all very positive. We also have the opportunity to avoid heart surgery by taking a pill or have other options by taking medications that cause us not to have to go into inpatient care in the hospital.

A lot of good has happened. We are now at a point where it makes sense to update Medicare. The question is how to do that. We really have two different views on how to do that.

One that I share says we should take a system that has worked and we should make sure it is fully funded so our physicians and hospitals and home health care and nursing homes have what they need to provide services. That is another critical issue—the resources being pulled out of Medicare and the underfunding of Medicare which has caused problems. We should provide full funding, and we should make sure it is modernized to cover preventive efforts and that we cover prescription drugs as a part of an integrated, modern health care system

under Medicare. We should use more technology so there is less paperwork and more streamlining, which I know is of great concern to health care providers. We can do all that within the framework of Medicare, which has worked so well. Why is that important? Because it is dependable, reliable, affordable, and it is a value statement about who we are as Americans. That is one view.

Another view is we should move back to the model before Medicare came into existence, and that is more of a reliance on private health insurance plans. We hear from many insurance carriers that they are not interested in prescription-only policies. They are not interested. It is different. Insurance usually means you provide insurance to a large number of people assuming only some of them will get sick or some will have automobile crashes or some will have their homes burn down—not everybody.

In the area of prescription drugs for seniors, from an insurance model it is very different. In fact, when you cover people, you can be assured almost all of them, if not all of them, will in fact need your insurance. They will need your coverage. So it is a very different kind of model than traditional insurance, where only some people use the insurance but everybody is paying into a system and spreading the risk.

That is one of the difficulties we have had, trying to fit this model of private insurance into the fact that we are talking about private insurance for health care, prescription drug care, where everyone who is buying the product will be using it. There are a number of questions about how to fit that model in and make it work.

Then there are questions about why. Why do we do that? Why do we propose something that is complicated, that on the one hand provides choice, which is good, from the private sector, but on the other hand is convoluted and complicated for those who want to stay in traditional Medicare and not make them make that choice. That is one of the questions, Why is this happening?

From the pharmaceuticals' standpoint, they are very much opposed to seniors being under one plan, 40 million people in one place, to be able to negotiate large discounts in price. As a result of that, they certainly have lobbied very heavily for a plan that divides seniors into a lot of different places so they have less leverage to be able to lower prices and negotiate discounts. That is also a concern of mine.

We know also that under traditional Medicare, we actually save money. We hear all the talk about market forces and lowering prices. In reality, facts show the opposite. In fact, common-sense I think shows the opposite when we look at what is happening in the private sector today. The average small business has seen its insurance premiums double in the last 5 years. Certainly in Michigan, major high-tech manufacturing in the State has seen 15

or 20 percent or more increases in the cost of private health insurance every year. Yet under Medicare we see the costs going up about 5 percent a year.

We look at this and say: Wait a minute, we are talking about a plan that costs more, not less. How does that make sense?

We also know, when we look at administrative costs, we are told by those who have analyzed it that administrative costs for Medicare to administer the program are about 2 percent. In the private HMOs in place right now under Medicare, their costs are 15 percent for administration. We are told that in the private sector they actually go higher, that in some private plans it has been as high as 31 percent for administrative costs.

We look at that and say, How does this make sense? We don't want 15 percent going into administration when it can be 2 percent so more of those precious dollars that we have can then go into buying medicine. That would seem to make sense.

There are a number of different reasons I believe it makes sense to make sure the real choice seniors want to have, which is traditional Medicare, is one of the choices available to them. I personally believe it will save dollars. It will allow the money we have to be used more for purchasing medicine and for health care rather than for administration or other kinds of costs.

Medicare is a nonprofit system by design. I know there are differences in philosophy about a for-profit system under health care versus a nonprofit system. But the majority of hospitals in this country are nonprofit. The Medicare system itself is set up so that every dollar possible goes into care. I believe that is a model we should continue. I believe it is a model, although it can always be improved—and I would be the first to say we can improve and streamline the Medicare system—fundamentally it has worked for people. It has been there. It has been a system that has held down costs. It has been dependable and reliable for every single person who is an older American, or for a disabled person in our country. I wish we would embrace it rather than talk about dismantling it.

I ask colleagues to come today, as we vote on this amendment, and join together to provide real choice for our seniors, the choice they are asking for as well as every other choice. Let's make sure every choice they might want to have they could have, including traditional Medicare.

Mr. President, I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

The Senator from Oregon.

Mr. SMITH. Mr. President, I rise to respond to the Senator from Michigan. I think she makes a number of points that are worth our consideration. I think this can be done through the Government route. But the grand experiment here is predicated on a belief that the marketplace can actually work.

If we were to adopt the Stabenow amendment, it would clearly undermine the private sector from forming plans and offering prices which have the potential of very real savings for our seniors and providing us with some very real reforms which seniors are counting on; that is, that we provide this benefit without undermining the financial integrity of Medicare.

We need to make up our minds. We can either go the Government route or we can go the market route. The Government route can work but it comes at a cost that is, frankly, hard to calculate.

Even as we speak, right now on Part B Medicare, the Government is looking at gross overpayments already on prescription drugs and is having to make reimbursements because of that.

Imagine all of the inefficiencies that would be infused into the system if we relied upon the Federal Government to manage every prescription drug for every senior in this country. If they are overpaying on one and wasting money at the same time, I hate to think of the bill the Federal Government would have to foot if we did this for every senior on the basis that the Senator is describing.

Moreover, the Congressional Budget Office has just announced an initial estimate of what the Stabenow amendment would cost, which is an additional \$50 billion over 10 years. Without a doubt, with the budget that provides \$400 billion over 10 years, this would exceed that by \$50 billion. I am sure at some point a manager of the bill will make a budget point of order. It has come at a significant additional cost of \$50 billion.

Again, I return to the point that we can either let the marketplace work or we can let the Government do it. But if you have a permanent Government backup as opposed to a fallback provision until the marketplace develops, you will retard, if not destroy, the marketplace from ever developing. It is that simple.

The predicate of the compromise between Republicans and Democrats that has been a result of the prescription drug benefit coming to our seniors is that we are going to have a fallback. But we are going to give the marketplace a chance. We are going to see which one works. As for me and my money, I am placing my bet on the marketplace, if we provide an economic structure for it to develop. If it develops, it will give real hope and a real renewed life to Medicare, and it will give our seniors the benefit they need of a prescription drug immediately. I think that is the better vote. I think it is the better way.

I think we know how Government works. When it is necessary for a Government bureaucrat to be between you and your medicine cabinet, I shutter, frankly, at the inefficiencies that can come from that; whereas, if you allow the marketplace to work—as with PPOs which the Presiding Officer and I have as Federal employees—frankly, they can take a holistic approach to your health by including prescription drugs. It gives us a very real chance to give our seniors a program that includes prescription drugs, which includes holistic health care, and which doesn't rely on a Government formulary and Government price setting to determine what drugs you can have and what they are going to cost.

I urge my colleagues to vote no on the Stabenow amendment because it undermines entirely the bipartisan agreement that has been arrived at in the Finance Committee.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, my friend from Oregon was speaking about medicine cabinets. On the question of whether you want a for-profit insurance company or a bureaucrat between you and your medicine cabinet, or whether you want Medicare, which we have known and relied upon since 1965, I appreciate that there is a different view and philosophy. I think there is a fundamental difference in ideology that is working here.

It is interesting. I had a chance to go back to the debates when Medicare was first developed. The same kind of differences occurred at that time and the same debate about whether or not we should provide care under one plan under Medicare that is stable and reliable or use the private market private insurance company. The very same kind of debate was going on then that is going on now.

I believe the right choice in 1965 was Medicare. I believe it continues to be one of the choices that makes sense to offer to seniors.

I wish to respond to the Congressional Budget Office estimate. It is disappointing to me to find that they have chosen to score it at \$50 billion above the \$400 billion. We have worked with them. In fact, we made it clear that the intent of this amendment was not to add \$1 to the budget resolution. It is to use the \$400 billion and within that to have a carve-out or choice of Medicare. In fact, so as to guarantee that, we included at the end of the bill an authority to prevent increased costs. If the administrator—in this case we are talking about HHS—determines that Federal payments made with respect to eligible beneficiaries enrolled in a contract under this section exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare prescription drug plan or Medicare Advantage, the administrator may adjust the requirement or pay-

ment under such a contract to eliminate such excess.

The reason we have included that is to guarantee that it is within the \$400 billion parameter. If, in fact, the Congressional Budget Office has not looked at that, it is unfortunate. I would disagree with their analysis.

I indicate again that this is not about changing the budget resolution or the amount of dollars. It is about creating the best choice or one more choice. It may not be the best for an individual. They may decide that going through a PPO or an HMO or some other part of the alphabet might be a better choice for them. The question is whether people will have a full range of choices including the choice that the overwhelming number of seniors have told us they want.

The intent of this amendment is in fact not to add anything to the cost of this particular bill.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mrs. HUTCHISON. Mr. President, I have heard the Senator from Michigan describe her amendment. I have to say I would be concerned about a Government-run prescription drug benefit because of what it would do to our free enterprise system and our capability to have competition which I think is very important. I think the underlying bill provides the competitiveness that will be so important for a balanced system, and it is also one that will give seniors the best prices and the best choices.

I would like to make a statement in general about the bill we have before us. I have to say that we have been talking about reform of Medicare for years—maybe for the 10 years I have been here. But today we are now talking about a real bill and maybe a real chance to reform this very important program.

I think it is clear that any time there is reform we must include a prescription drug component. We must have a choice which is similar to that in the private sector, and we must admit that Medicare has not kept pace with the rapid changes in our health care system.

As our research community pushes the envelope and develops lifesaving medicines and procedures, our Nation's health care system must take that innovation into account or it will not be the greatest health care system in the world.

Pharmaceuticals have revolutionized medical care. Increasingly, ailments are treated with medication as opposed to invasive surgeries. It is imperative that those who rely on Medicare have access to affordable prescription drugs.

When Medicare won't pay for medicine to treat diabetes but will pay for the amputation of a limb caused by complications of diabetes, I think we can admit that we have a problem.

A prescription drug benefit alone is not the answer. True reform must provide our Nation's seniors the freedom to choose physicians and benefits based on their individual needs. If a beneficiary is satisfied with existing coverage, the beneficiary should have the option to stay put. But if she chooses to enroll in a private insurance PPO or HMO, she should be allowed that choice. This choice is incorporated in the underlying bill.

Also, I have an amendment, cosponsored by Senators KENNEDY, DURBIN, SPECTER, and TALENT, to restore cuts in Medicare reimbursement to teaching hospitals. Texas hospitals are facing the loss of \$26 million in 2003 due to Medicare reimbursement cuts. Nationwide, teaching hospitals will lose \$794 million this year and \$4.2 billion over the next 5 years. Every State will be similarly affected.

Teaching hospitals are experiencing a terrible financial crisis. My amendment restores the fiscal year 2002 level of reimbursement for indirect medical education—they are called IME payments—to teaching hospitals. This allowance has been cut incrementally since the Balanced Budget Act of 1997 from 7.7 percent to 5.5 percent in fiscal year 2003.

Teaching hospitals have higher costs due to their critical role in educating tomorrow's physicians. They run more tests, they have newer technology, and they require more staff because they are training our future health professionals. The additional payment is vital to continuing this training. A disproportionate percentage of the most seriously ill and injured patients recover and convalesce in teaching hospitals. These hospitals have 78 percent of all trauma centers and 92 percent of all burn beds.

Although only 21 percent of all hospitals are teaching hospitals, they deliver over two-thirds of charity care. They conduct groundbreaking research. The University of Texas Medical Branch in Galveston—as one example in my State—will lose \$1.9 million in these payments this year if the amendment is not adopted. UTMB leads research on anthrax, smallpox, and plague. We cannot afford to have teaching hospitals cut back on research that benefits every individual.

In the budget we passed earlier this year, \$400 billion was set aside for Medicare reform. It is our responsibility to use that \$400 billion wisely and to bring this incredible program into the 21st century so that America's seniors will have the medical coverage they need and deserve.

I think the bill before us needs work. We all agree that it is not a perfect bill and we want to make it better. We want to make sure it does two basic things: that it increases the quality of

health care for our seniors, and, secondly, that it does so at a reasonable price for our future generations. We do not want another huge commitment that is going to turn into an entitlement that is unbearable in the future. But when Medicare will cover the cost of a hospital stay for 5 days for the amputation of a limb but it will not allow you to pay for the medicine that will keep you from having to amputate that limb, something is wrong in the system, and we must fix it. This time we can do it.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I have been listening to this debate and listening to the distinguished Senator from Michigan. If you love the Federal Government and the Federal Government's control over all of our lives, boy, this is the program for you, because it certainly would fly in the face of everything we have been trying to do to create a program where you have some options, some choices, and where people can make their own decisions as to what type of health care they want, seniors in particular.

So I rise in opposition to the Stabenow amendment. The way I understand the amendment, it would require a permanent fallback to be offered to beneficiaries in addition to the private stand-alone drug plans. Making the fallback plan a permanent option will completely undermine the very structure upon which this bill is built.

First and foremost, including a permanent fallback plan creates an uneven playing field. Frankly, we hope the Government fallback plan is never needed. The only reason it is in this bill is to take care of those situations where there are no bidding competitors to provide the health care. We believe there would be bidding competitors, and there is no real reason to have a fallback other than in those rural areas or tough areas where it is uneconomical for business to compete for the business, where you are going to need a no-risk, Government sponsored and subsidized, and completely controlled fallback plan.

So first and foremost, including a permanent fallback plan creates an uneven playing field. The Government fallback is a non-risk-bearing entity. The fallback plan will operate in regions without any risk for gains or losses. The Government pays for the fallback plan's administrative costs associated with delivering the drug benefit. If we make the fallback plan permanent, as the distinguished Senator from Michigan would do, we are basically requiring privately delivered drug plans, which are at least partially responsible for bearing the risk of delivering this benefit, to enter this same market and compete with these Government fallback plans.

This would not only be unfair, but it also sets up our drug plan for failure.

There isn't a private health plan out there that will enter such a lopsided market where we give their competitors such a large financial advantage. Simply put, this amendment would discourage the initial entry of private plans, dooming the effort to provide beneficiaries the drug benefit through competing private plans with all of the cost savings and benefits that would come from competition.

In addition, including a permanent fallback plan would add billions of dollars to the cost of this bill. CBO estimates that the cost of this fallback plan would be at least \$50 billion over 10 years. So, literally, by including a permanent fallback plan that will cost \$50 billion-plus over 10 years to the cost of this bill, we would be relying, at least partially, on an inefficient, more costly, Government-controlled, Government-style delivery system to provide beneficiaries with drug coverage.

When the Senate was debating the Medicare prescription drug issue last year, this was one of the biggest criticisms against the Graham drug benefit. The Graham drug benefit plan created a one-size-fits-all drug benefit delivered by the Federal Government. This is not what Medicare beneficiaries want.

Beneficiaries want choice in drug coverage. They do not want to be forced into a Government-run plan and offered a one-size-fits-all benefit. The Stabenow amendment would place the drug benefit right back in the hands of Government-run health care, Government micromanagement, and, worst of all, price controls. Government bureaucrats would ultimately put the Government in charge of setting drug prices. We simply do not want Government bureaucrats in charge of setting drug prices. We want the private market to make these decisions, not the Federal Government.

My colleague from Florida was just reminiscing about the 1988 catastrophic law. I was here. I argued against it. We all saw the people jumping up and down on Danny Rostenkowski's car when they realized they had to pay for their drug expenses. Well, you can imagine what is going to happen if we have Government take over this program.

If this amendment passes, we will be creating another Medicare catastrophe. In fact, we already know the Federal Government does not do the best job of reimbursing for prescription drugs due to years of overpayments for the drugs already covered under Part B of Medicare.

Medicare has been overpaying for Part B drugs for years because of its inability to keep up with the marketplace. The intent of S. 1 is to introduce a new model to deliver care to Medicare beneficiaries. We want to offer Medicare beneficiaries a meaningful drug benefit. This drug benefit will include multiple choices but it only works when all options are expected to participate under the same rules. You

don't set it up so that all the options that have a chance of working fail because you have a government-run, government-subsidized, government-controlled, government-bureaucratized program, which is exactly what the Stabenow amendment would establish.

Those who are extremely liberal will love that program, because it just means Government controls every aspect of our lives in health care. In S. 1, we included the Government fallback as a safety net to ensure that every senior has access to pharmaceutical drug coverage. But it is a fallback of last resort. We hope we will never have to have a fallback plan for any region or any area. But it is a last resort, if we need it. That is because even the Congressional Budget Office concludes that the permanent fallback plan is a more costly, less efficient model to deliver pharmaceutical benefits.

Again, let me remind everybody that the CBO says the Stabenow amendment will cost at least \$50 billion over the next 10 years. Knowing the Government as I do, I say at least \$50 billion. It will probably be a lot more than that. It will take all the incentives to keep costs down out of the program, as we take away risk, which is what the competing companies have to meet. They have to meet risk factors.

In conclusion, the Stabenow amendment would deny Medicare beneficiaries the opportunity to enroll in the plan that best fits their needs. They would be denied that opportunity. The Stabenow plan would force all our seniors into a government-run, government-controlled, government-bureaucratized drug benefit. It would basically undermine every possible competitive aspect that might possibly hold costs in line and bring them down.

This amendment by the distinguished Senator from Michigan would effectively deny beneficiaries a private plan option thus denying beneficiaries a choice in drug coverage, one of the fundamental principles of this bill—choice, the right to pick the coverage you want. That is what our prescription drug program would give beneficiaries.

There are those who believe that socialism is the answer to everything. Let government do it. Government can do it more efficiently. If you believe that, you haven't watched the last 50 years. I urge my colleagues to defeat this amendment because it will take away important drug coverage choices for Medicare beneficiaries. It will lead us into a situation where Government is going to control everything, and, as a result, Medicare beneficiaries will be left with no choices in drug coverage. I don't want to go back to those days when they were jumping up and down on Danny Rostenkowski's car because the senior citizens realized they had to pay for it. I want to give Medicare beneficiaries choices and make sure there is some competition in the marketplace so that the choices will be good ones. I don't want to go to just a

one-size-fits-all government program which literally will not work except at a tremendously costly expense to U.S. taxpayers.

For these reasons, I urge my colleagues to oppose the Stabenow amendment.

I yield the floor.

Ms. MIKULSKI. Mr. President, I want a medicare prescription drug plan that benefits seniors—not a plan that benefits insurance companies. That is why I am a cosponsor of the Stabenow amendment.

This amendment gives seniors a choice: to get their prescription drugs through traditional Medicare or through a private insurance company.

Why is this important? Because it lets seniors choose the program that fits their needs. Seniors trust Medicare. It has provided a safety net for seniors for almost 40 years. Medicare hasn't let them down.

We can't say the same about insurance companies. We have been down that road in Maryland with Medicare+Choice. The insurance companies came in. They enticed seniors with promises of better care and prescription drugs. They took the money from our seniors and left town leaving over 100,000 Maryland seniors without coverage.

Seniors in my State were gouged and abandoned. So I don't trust insurance companies to be there for seniors. I trust seniors to make their own decision to decide which prescription drug plan is best for them.

Seniors trust Medicare. When given an opportunity, I think seniors will choose Medicare. In the mid-1990s, when Medicare HMOs offered prescription drug benefits. Only about 15 percent of beneficiaries signed up.

Yet year after year, Senate Democrats have fought off efforts to privatize Medicare—to force seniors to leave their family doctors and join HMOs and other private plans. We heard Newt Gingrich talk about making Medicare “wither on the vine.” Then this year, the President's prescription drug proposal would have forced seniors to leave the Medicare they trust to get the drugs they need.

I believe honor thy mother and father is not just a good commandment to live by. It is good public policy to govern by. That is why I feel so strongly about Medicare.

Medicare is not the problem. It is the solution. That is why Congress must now provide a prescription drug benefit for seniors. To benefit seniors—not to benefit insurance companies. We must do it now—to help seniors, to help families, to help American business and to help our economy.

I urge my colleagues to join me in supporting the Stabenow amendment.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH. Mr. President, I ask unanimous consent that the vote in relationship to the pending amendment No. 931 occur at 3:15 today with no

amendments in order to the amendment prior to the vote and 5 minutes for debate equally divided prior to the vote.

I further ask unanimous consent that at 2:15 today the amendment be set aside and Senator ENZI then be recognized to offer an amendment.

Mr. REID. Reserving the right to object, the senior Senator from Illinois is on the floor. I am wondering how long the Senator wishes to speak on the Stabenow amendment. If the Senator from Oregon would allow the Senator from Illinois to speak until 2:15 on the Stabenow amendment.

Mr. SMITH. I have no objection.

Mr. REID. I would ask for a modification; that we be recognized for 10 minutes; following that, Senator ENZI be recognized after the Stabenow amendment is set aside.

The PRESIDING OFFICER (Mr. ALEXANDER). Is there objection to the modified request?

Without objection, it is so ordered.

The Senator from Illinois.

Mr. DURBIN. Pursuant to the unanimous consent request, it is my understanding I am recognized for 10 minutes.

The PRESIDING OFFICER. That is correct.

Mr. DURBIN. Mr. President, at about 3:15 we will have a chance to vote on an amendment. It is an important amendment to the prescription drug plan, an amendment offered by my colleague and friend Senator STABENOW of Michigan, who has been our leader in the Democratic caucus on the prescription drug issue. There is no one who has put more time in it. Senator STABENOW is going to give the Senate a very basic choice to make.

Under the Grassley-Baucus bill, a senior citizen, once this goes in effect after the Presidential election, will take a look at the area they live in and if they can find two private providers for prescription drugs, they have to choose between the two of them. If they can't find two that will provide that protection, that service, then there will be a Medicare plan known as a fallback plan which the senior can turn to, but it is not a plan that will be administered by Medicare. It is a plan that will be administered by a private provider under Medicare. So no matter where you turn as a senior under this plan, you are always going to find a private provider, a private insurance company.

The Republicans, many who support the bill, argue that is real competition. Senator STABENOW takes it to another level and says, if you want real competition, one of the options that should always be available to the senior is to go to a prescription drug plan administered by Medicare itself.

Why would you want a Federal agency to administer this plan? I will give you two reasons. First, there is no profit motive. Medicare is basically going to be involved in this to try to provide

the service, and we know that the services they provide are at a lower administrative cost than any private insurance company. No. 2—and this is where the rubber meets the road—Medicare can say to the drug companies, we want you to be part of the Medicare alternative; therefore, tell us what you will do to contain the cost of your prescription drugs. So they have bargaining power on behalf of seniors to reduce the overall cost of drugs that are offered to seniors, a win/win situation.

Does it work? Go to the Veterans' Administration hospitals. Look what they have accomplished. They said to the drug companies, you want to sell drugs to veterans, great. But tell us the best price you will give us, and the best price offered at veterans' hospitals to the men and women in uniform is 40 to 50 percent below what seniors are paying over the counter for their prescription drugs across America today. So if you go to the Stabenow alternative, a Medicare-administered plan, no profit motive, low administrative cost and a formulary, a group of drugs that has been discounted for seniors, it is an absolute win situation for seniors and for the Government and for the cost of the program.

Those who are arguing for competition on the other side say, just let these private providers get at it. Boy, they will really show you how they can bring prices down. They live in fear that if Medicare is involved in it, Medicare will show them how prices can really come down. That is what this is all about.

I hear these arguments on the floor from people who I respect saying the Stabenow amendment is going to limit choices. The heck it will. The Stabenow amendment gives to seniors the real choice, the Medicare choice, the choice that they want.

I would like to ask the Senator from Michigan if she will respond to a question. She has a chart that shows the interests of senior citizens on this issue. If this is any indication, how would the senior citizens vote on the Stabenow amendment?

Ms. STABENOW. First, I thank my colleague for his eloquence. It is true that 89 percent of the seniors in this country are in traditional Medicare. Only 11 percent are currently in managed HMO plans. Since 1997, seniors have been given a choice between what has been called Medicare+Choice and traditional Medicare. Overwhelmingly, they have stayed in Medicare.

Mr. DURBIN. Does the Senator's amendment limit the choices for seniors—

Ms. STABENOW. Absolutely not.

Mr. DURBIN.—when you compare it to the underlying bill?

Ms. STABENOW. Absolutely not. What we are doing is saying, instead of two private insurance plans, we add a third, so instead of two choices, you have at least three.

Mr. DURBIN. Again, let me ask, through the Chair, if I might, is it not

true that if Medicare then can offer this plan on behalf of tens of millions of seniors, Medicare can go to the drug companies and say: All right, you want to sell us Celebrex or Zoloft or whatever; what is the best price you will offer Medicare?

Isn't that more of an assurance that the prices seniors will pay under that alternative will be lower?

Ms. STABENOW. Absolutely. The Senator from Illinois has hit what I think is the most critical point, and the reason there is such opposition, certainly from the pharmaceutical industry, to what we are trying to do through Medicare. They don't want the majority of seniors in one insurance plan together in Medicare where they can force a group discount. They would like to divide seniors up in lots of different insurance plans and not give them the leverage to bring prices down.

Mr. DURBIN. Also, I ask, under the underlying Grassley-Baucus bill, what force is there for cost containment? What kinds of elements are in that bill that will help bring down the cost of prescription drugs for America's families and America's seniors if we don't put Medicare into the process bargaining on their behalf?

Ms. STABENOW. I don't see anything in here that brings it down. In fact, what we are doing in the underlying bill is adding the profit. We are putting for-profit business into this process, so you are actually adding to the cost of this system. I don't see anything in here that will bring prices down. I think that is why the pharmaceutical industry is very supportive of this plan because, unfortunately, the average retail price of an advertised brand is going up three times the rate of inflation. This does nothing to address that and bring the prices down.

Mr. DURBIN. I thank the Senator.

While I still have a minute or two, I will just say this. Time and again, our friends on the Republican side of the aisle say we should contract out Government services, privatize them, to save the taxpayers money. They say, if you will just get it away from the Government bureaucracy and put it into the private sector, we will show you how to really provide a service at a low cost. Sadly, many times that doesn't happen. The costs go up, the quality is not good, and we are stuck with private-side contractors when we contract out.

Now we have an interesting turn of events. We hear from the Republicans and conservative side that we don't want a Government agency to be able to compete with the private sector. We don't think that is going to be fair. There is no real choice there.

There is a choice. I think the choice is obvious. If Medicare—speaking for the vast majority of senior citizens—can bargain for lower prescription drug prices, the winners will be not only the seniors who will pay less but the taxpayers who will pay less. The \$400 billion in this bill will go a lot further if

we can have lower cost prescription drugs.

I say to my friends on the Republican side of the aisle, don't be afraid of competition, and don't be afraid if one of the competitors is Medicare. The seniors who you represent have already voted on this issue by a 9-to-1 margin. They prefer traditional Medicare. We should not be afraid of it.

The Stabenow amendment is a step in the right direction. It says if we are going to have a prescription drug plan that Americans can afford and that the taxpayers can afford to pay for, yes, we need to have cost containment. This bill has little or none. The Stabenow amendment brings in real competition and, unless that competition is there, let me tell you what we have done; we have said we will subsidize prescription drug costs no matter how high they go. Mark my words, as history has proven, they will continue to increase to a point where it bankrupts the current bill before us.

The Stabenow amendment is, I think, not only a stand for common sense but a guarantee that competition will really be there to protect seniors.

I yield the floor.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I will use my leader time. I am not sure what the allocation of time is right now.

I commend the distinguished Senator from Michigan and the Senator from Illinois for their work on this particular amendment. I think I can say for most, if not all, of our caucus members, this is the most important amendment as it relates to this bill, in large measure because it goes to the essence of what it is we believe we need to do.

What we have said from the very beginning is let's build on what we have achieved in the Medicare system now for the last 38 years. Obviously, we know there are ways in which the program needs to be updated and reformed. I think there is common agreement among Republicans and Democrats that if we are to reform Medicare, the single most important priority is to ensure that we recognize that health care delivery has changed dramatically in the last 40 years.

Health care delivery now is largely outpatient. Far more people get their health care in an outpatient setting than they do inpatient. With that recognition, we made a decision in the 1960s that was wrong. We said we would reimburse drug costs in a hospital but we would not reimburse drug costs outside of a hospital or doctor's office. Well, had we decided back then that we would reimburse drug costs regardless, we would not be here today. So we made a decision based on, I am sure, a lot of different factors—cost was probably important—that we wish now we could have reversed a long time ago. But that, in essence, is what we are talking about with reform. It is a recognition that health care delivery itself has changed.

The real question is, What will be the mechanism by which seniors acquire these prescription drugs? There are those who have suggested that seniors ought to have choice. I have heard the distinguished Senator from Michigan say so eloquently that if you are in favor of choice, you will be in favor of this amendment because that is basically what we are proposing—choice. We are saying to seniors, if you think you can find a better plan out there somewhere, offered within your region, take it. This is a voluntary program. We are not mandating that you do anything. But if you think Medicare has provided a good service and if you think, in order to be consistent with the spirit and the concept of Medicare to begin with, that it ought to be offered through the Medicare system, you ought to have a right to choose that as well.

Why in Heaven's name would we deny a senior the right to stay within Medicare when they get their doctor and hospital benefits through Medicare? They ought to get prescription drugs through Medicare. So that is, in essence, what the Senator from Michigan is suggesting with her amendment. Let's allow choice; let's allow consistency.

But I think it goes beyond the choice of the senior citizens. The reason it ought to be our choice occurred again last night to me as I listened to some of the debate in the House Committee. The question was asked last night: Can you tell us what the administrative costs will be for the private sector systems providing this new prescription drug benefit? On record last night during that debate the answer was given: 25 percent.

The administrative costs for the private sector plans is anticipated to be 25 percent. That means out of the \$400 billion we are committing to the drug program under this legislation, \$100 billion could go to paperwork.

We have asked what is the administrative cost of the Medicare system, and we are told by CBO and others that the administrative cost today for Medicare is between 3 and 4 percent. So we could save upwards of 20 percent if we had an opportunity for seniors to use the Medicare system. That is another reason that choice would make sense to us—to keep administrative costs down.

We only have to look to the Veterans Administration to see how effectively they have controlled costs, not only administratively but on drug acquisition costs. The drug acquisition cost through the Veterans Administration is dramatically lower, ranging anywhere from 15 to 30 percent below what is done in the private sector through private insurance companies. We could save in Medicare as well.

From a cost containment point of view, an administrative point of view, and a choice point of view, this amendment ought to pass. I think it is key to sending the right signal not only to our

seniors about what kind of services we want to provide, about what kind of consistency, what kind of choice we want to offer, but it ought to be a message to the taxpayer. We are going to do it through the most efficient, most administratively simple concept to which we can subscribe. Extending Medicare, providing drug benefits through Medicare, is the way to do it.

Again, I commend the distinguished Senator from Michigan for her efforts and for her amendment. I hope it will enjoy broad bipartisan support. I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Wyoming is recognized.

AMENDMENT NO. 932

Mr. ENZI. Mr. President, I send an amendment to the desk, and I ask unanimous consent that the pending amendment be set aside until 5 minutes before the vote.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for himself and Mr. REED, proposes an amendment numbered 932.

Mr. ENZI. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To improve disclosure requirements and to increase beneficiary choices)

On page 57, between lines 21 and 22, insert the following:

“(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the Medicare Advantage organization offering a Medicare Advantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

“(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D-7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a Medicare Advantage organization offering a Medicare Advantage plan.

On page 37, between lines 20 and 21, insert the following:

“(C) LEVEL PLAYING FIELD.—An eligible entity offering a Medicare Prescription Drug plan shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in cost paid by such enrollees.

“(D) PARTICIPATING PHARMACIES NOT REQUIRED TO ACCEPT INSURANCE RISK.—An eligi-

ble entity offering a Medicare Prescription Drug plan may not require participating pharmacies to accept insurance risk as a condition of participation.

Mr. ENZI. Mr. President, I rise today to offer an amendment that will contribute to fair prices for consumers and fair treatment for pharmacies under the new Medicare prescription drug benefit. I am pleased that my distinguished colleague from Rhode Island, Senator REED, is joining me in offering this amendment. He serves with me on the Health, Education, Labor, and Pensions Committee and has been a stalwart in helping with some of the small pharmacist issues. That is what a large area this bill seeks to take care of.

It is an issue across the entire country. It is not just an issue in Wyoming or the West. We all have local pharmacists. Local pharmacists provide a tremendous service to the people for whom they are providers. One of those local services is to explain how the drugs are used, what their proper use is. They have an excellent knowledge of the drugs a person is taking and recognize conflicts and iron those out with the doctor. They work with the doctor to come up with some generic drugs, in some cases, to save costs. Largely, they are left out of any of the pricing mechanisms. They do all of this on a very low margin.

This bill does not take care of that part of local pharmacists, but it allows them to still be in the market. This bill ensures fair prices for consumers.

The amendment we are proposing would ensure that we hold Medicare drug plans accountable for passing on to consumers a fair portion of the rebates, the discounts, and the other incentives that the plan may receive from drug manufacturers and other sources.

Specifically, the amendment would require Medicare prescription drug plans and Medicare Advantage organizations to disclose to the Federal Government the extent to which they pass those rebates and discounts on to Medicare beneficiaries.

The amendment would also clarify that the Federal Government may audit their financial statements and records to ensure compliance and deter fraud and abuse in this area.

To ensure fair treatment for pharmacies, the amendment we are offering would prohibit Medicare drug plans from implementing restrictions that would steer consumers to the mail order pharmacies. It would require the Medicare drug plans to allow local community pharmacists to fill long-term prescriptions—not just 30-day prescriptions, but 90-day prescriptions—and offer other services they are equipped and licensed to provide. It protects the rights of seniors to choose their trusted local pharmacist over a mail order house.

Our amendment would also prohibit Medicare prescription drug plans and Medicare Advantage organizations from requiring pharmacies to accept

insurance risk as a condition of participation in a plan. Pharmacists and pharmacies dispense medications and provide services; they are not insurance companies.

This provision will ease the minds of the pharmacists who are concerned that Medicare drug plans might force them to share the risk. This has come to light, I am sure, to all of us in town meetings we have held, town meetings where pharmacists have shown up, town meetings where the pharmacists either have their national publication or publications from their colleges that point out some of the difficulties they are having operating in the local market, the local market where they have the actual contact with the consumer, the local market where they are the ones providing the advice, the care, and sometimes the protection of the patient. We want to make absolutely sure we do not leave them out of the mix.

This is a part of the solution that has been suggested in those college publications and those national pharmacist publications. These are local professionals who provide a local service. They do an outstanding job of helping out their customers. They understand who the customer is because they see them face to face; they are not just a voice over the telephone taking an order.

They will play an important role in any drug benefit that is passed, whether it is through a profitable situation for them—and we hope they can stay in business so we have the help of this local pharmacist—or whether it is forced on them in a nonprofitable way. They have been doing that.

It would be nice if we watched out for the small businesses in the towns across America. Small businesses are the heart of America. They are the ones that provide the community help and community services. They are the ones that participate in all kinds of community events.

We have to be careful this bill does not take them out of the loop and put them out of business so that kind of service disappears from the face of America. It is part of America. The drug stores have been the heart of downtown for years and now the heart of the health care system. They are often the main source of health care service and advice, particularly in the rural and frontier areas. In the bigger cities, there may be more contact with people who can provide information. Some of that comes through the HMOs, and some of it comes through the prescription drug managers who are often tied in with those HMOs. But they are not the ones who really do the contact with the customer, particularly in the rural and frontier areas.

I sponsored a bill to remedy our pharmacist shortage, and I am hoping that bill will come to the floor. It is a bill that helps with the forgiveness of the loans it takes to get through the process of becoming a pharmacist. We have to make sure these people are available

and continue to be available in smalltown America and in the big cities. We also have to make sure there are faculty to teach these people properly to interact with the customers.

Half of the money would go to providing loan forgiveness for pharmacists who become faculty and half to forgiveness for people who actually become pharmacists in underserved areas, and underserved areas are sometimes urban areas as well. This bill does not address this. That is another bill we need to fill in the pharmacist piece. It unanimously came through the Health, Education, Labor, and Pensions Committee, and it recognizes the need for local pharmacists and that local interface we are all used to having. Seniors and pharmacists are both concerned with how the interaction will happen. Seniors do trust their hometown pharmacist.

Senator REED and I believe this amendment will go a long way toward answering the concerns of seniors and pharmacists about how this new Medicare drug benefit will impact the trusted relationship that pharmacists and their senior patients share.

I encourage all of my colleagues to take a closer look at this amendment and help me get it adopted. As I mentioned, it has bipartisan support. If we had a little more time, I am sure we would have had a lot more cosponsors. We recognize this is an appropriate place for this amendment to appear and an appropriate service to provide under the prescription drug benefit of Medicare.

So I encourage my colleagues to vote for it. I thank them for their consideration.

I yield the floor.

The PRESIDING OFFICER (Mrs. DOLE). The Senator from Oregon.

Mr. SMITH. I thank my colleague for his amendment. I think the Enzi-Reed amendment will clearly improve beneficiaries' access to long-term prescriptions at their local pharmacies, as well as to increased disclosure requirements for participating plans. Community pharmacists play an integral and active role in health care delivery by providing programs that help patients manage their disease, prevent dangerous drug interactions and educate and counsel on the proper use of their medications. Any prescription drug program will rely heavily on community pharmacists.

Under S. 1, the underlying bill, entities eligible to offer a Medicare prescription drug plan would be required to ensure that beneficiaries have convenient access to community pharmacies in both rural and urban areas. Additionally, no eligible plan would be allowed to offer prescription drug coverage solely through mail order pharmacies.

The Enzi amendment builds on the provisions already included in S. 1 and would ensure that beneficiaries who enroll in prescription drug plans and Medicare Advantage plans that offer

mail order benefits would also have the option to fill long-term prescriptions in community pharmacies. This amendment also would provide beneficiaries flexibility, convenience, and increased corporate reporting requirements for Medicare prescription drug plans. This should promote, not stifle, competition and improve choice.

So let's be clear. There are efficiencies inherent in mail order pharmacies and beneficiaries would continue to benefit financially by purchasing drugs through the mail, but this amendment would provide them with yet another choice, another option, as well.

It is certainly my intention to vote for the Enzi-Reed amendment. I am not in a position to say that the chairman is saying that yet, but I suspect he will.

I understand Senator ENZI will speak for a few more minutes.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. I thank the Senator from Oregon for his comments. He has very concisely laid it out, has a tremendous understanding of this amendment and the need for it, and made a fair assumption that it could cost slightly more by going through the local pharmacist. But one of the things we want to do is make sure that local pharmacist is an option.

If beneficiaries getting the prescription drugs order it through the local pharmacy and the cost comes to more than it would be through a mail order firm, then the person receiving the prescription drugs does have to make up that difference in cost.

These four provisions in the amendment will make a tremendous difference to both consumers and to pharmacists. The aim is twofold. It is to have fair prices for consumers and then fair treatment for the local pharmacies. As was mentioned, the two provisions that require fair prices would require the Medicare prescription drug plans and Medicare Advantage organizations to disclose, to the extent that they pass Medicare beneficiaries, any rebates or discounts that they negotiate from drug manufacturers. In other words, if they get a break, the consumer is supposed to get a break. It permits the Government to audit the plans and the organizations' financial statements and records—and it is primarily the records that are important—to ensure compliance to make sure there is not fraud and abuse and to make sure, again, that those reductions get passed through to the consumer. So we want fair prices for consumers.

The consumers and pharmacies do support the first two provisions aimed at ensuring this transparency and accountability on the part of pharmacy benefit managers, PBMs, the companies that will probably win contracts or bids to manage the new drug benefit.

Pharmacies argue that the pharmacy benefit managers, the PBMs, are

squeezing their margins while consumers argue that the PBMs have financial incentives to steer patients to the drugs that make the most profits for the PBMs, even when they may not be the most appropriate drugs for the patients. So that is another reason that not only the fair price but the transparency has to be there.

What are these PBMs, pharmacy benefit managers? PBMs administer prescription drug benefits through contracts with employers, managed health care organizations, and insurance carriers. Today, the top 20 firms manage more than 90 percent of retail prescription drug purchases, and three firms, AdvancePCS, Express Scripts, and Merck-Medco Managed Care, dominate the market.

Large self-insured employers turned to PBMs during the 1990s to administer the popular drug benefit, to manage the costs and utilization trends to ensure appropriate use of drugs and improved quality care. However, the employer frustration over rising costs and questions about appropriateness of drug use are stimulating interest in PBM contractual relationships, especially financial arrangements with drug manufacturers, and the bearing those relationships have on the PBM performance.

PBMs once earned the bulk of their revenue by holding down drug costs for health plans. They now earn a large portion of their revenue from drug companies that pay them undisclosed rebates and other financial incentives for promoting certain medications. For nearly 4 years, the U.S. attorney's office in Philadelphia has been looking into how PBMs negotiate discounts, rebates, and payments from pharmaceutical manufacturers and how the resulting revenues are shared with PBM clients.

So what does the amendment do to answer the concerns? The amendment would give the Government the ability to ensure that the Medicare drug plans administered by PBMs are passing through the fair share of their rebates and discounts on to consumers. It would also clarify the Government's authority to audit the drug plans to confirm the accuracy of the disclosure of the rebates and discounts.

The main thrust of it is to make sure the local pharmacist has a fair shot for the service they provide. I hope everybody remembers when they go to a pharmacist the time he spends explaining how often they take the drugs and what they cannot take before or after, and what they can have with them. They also have an understanding of the other medications that people are taking so that if there is a possibility that there will be an interaction between two medications, they can solve that problem.

Of course, the only way that happens is if a person is working with one pharmacist. If people are calling a whole bunch of different pharmacists, because of privacy laws they do not have access

to the interaction of the other drugs that a person is taking.

So that local pharmacist provides a tremendous service, and it is only fair that we include those professionals in the ability to compete in this market, and people can continue to place their trust in the local person that they can see face to face and from whom they can pick up their prescriptions. It is a relatively short amendment, but again it is one that has very strong bipartisan support and one that will fulfill a need. So far as we know, there is very little opposition. So I look forward to having my colleagues support it.

Again, I thank the Senator from Oregon for his comments and this opportunity to present the amendment.

I yield the floor.

Mr. SMITH. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. REED. Madam President, I rise in support of the Enzi-Reed pharmacy access amendment.

I compliment my colleague and friend, Senator ENZI from Wyoming. We have worked on several issues with respect to the pharmacy benefits. It has been a pleasure and it has been productive, not only for ourselves but for the professional pharmacy community. Pharmacists are the third largest health care profession in the country in terms of numbers of practitioners, and they are becoming increasingly more central to our health care system.

This amendment is designed to accomplish two very important objectives with respect to the proposed Medicare pharmacy benefit for seniors. First, its aim is to assure transparency and accountability in the collection and dissemination of negotiated savings by Medicare prescription drug benefit plans and Medicare Advantage plans. Second, it is designed to guarantee Medicare beneficiaries access to community pharmacies when filling prescriptions of 90 days or longer. Without the Enzi-Reed amendment, these protections, these safeguards, these essential elements would not be present in the bill we are considering today.

This language is very similar to proposed language included in the counterpart legislation being deliberated in the other body. If we are to rely upon private companies to negotiate and administer a benefit on behalf of the Federal Government as well as on behalf of tens of millions of elderly and disabled beneficiaries, we need to be sure these entities operate with the best interests of these parties in mind and not simply and exclusively their bottom line. Through this amendment, plans will be

required to disclose to the Government the extent to which they pass on to Medicare beneficiaries rebates, discounts, and any other savings negotiated from the drug manufacturers.

We all recognize one of the essential elements of this legislation is the notion that private pharmacy benefit management companies will negotiate with pharmacies and manufacturers to get the best possible price. We hope that best possible price is passed on almost entirely to the beneficiaries and to the payers, which include the Federal Government. It would be ironic, indeed, if we establish a system in which the intermediaries gained huge profits, while the Government and beneficiaries continue to pay substantial sums for the pharmaceutical benefits.

By requiring disclosure of negotiated savings by drug plan administrators, we guarantee a greater degree of transparency and make sure beneficiaries are getting the best possible savings on their prescription drugs. The essence of the Enzi-Reed amendment is let the markets operate, but make sure everyone has complete information about who is reaping the benefits of these negotiated transactions between purchasers and suppliers of these pharmaceuticals.

Since beneficiaries are expected to pay anywhere between 50 percent and 100 percent of the cost of drugs—those individuals in the gap would be paying 100 percent of the cost of drugs—we have to make sure they are getting the best possible deal. This amendment will go a long way towards ensuring that actually happens.

If the PBMs do not pass these benefits and negotiated savings along to the public and the Federal Government, then we all should know. This amendment will ensure that level of accountability.

Second, the Enzi-Reed amendment allows beneficiaries to receive 90-day prescriptions and other related benefits through community pharmacies. Senator ENZI represents the great State of Wyoming in which a pharmacy—I am sure in some of the smaller communities—might be the only source of pharmaceutical supplies and medical advice and many other things. Pharmacies are an important part of the fabric of a community. To deny seniors the right to get their pharmaceutical supplies from these pharmacies would not only be wrong but inefficient. If that is where they would like to get their prescriptions, they would be assured they can get the benefit through the local pharmacy under this amendment.

Rhode Island is a little different from Wyoming, but pharmacies in Rhode Island have the same role in the lives of seniors, particularly in terms of getting their benefits and other important health care services. This amendment would allow beneficiaries to obtain 90-day supplies through the community pharmacist, wherever they are.

This does not exclude mail order, but it simply makes sure it is not the only option that seniors have; that they can continue to rely upon the local pharmacy for their benefits.

I should say something else. Not only is the local pharmacy a source of pharmaceuticals, it is usually an excellent source of advice and assistance by trained pharmacists. Increasingly, these pharmacists are taking on a very important role in advising seniors, within the limits of their practice, as to the appropriate use of pharmaceuticals and are also a source of advice on many other health care issues. So I hope my colleagues would agree that we should encourage the use of local pharmacies. This amendment will help do that.

I again commend Senator ENZI for his work and leadership on this issue. We share a common belief that professional pharmacy is a critical part of our health care system. If we allow pharmacists to operate, we will get the benefit of their expertise, and it will redound to the health needs of our seniors and to the financial responsibilities that we face in enacting this legislation.

I urge all my colleagues to support this amendment.

I yield the floor.

Mr. ENZI. Madam President, I thank the Senator from Rhode Island, Mr. REED, for his efforts on this bill and the efforts on all the other ones we worked on together over the years. We came to the Senate at the same time and served on the Health, Education, Pensions and Labor Committee since that time. I think we have been able to reach some reasonable solutions before, and we will have yet another one here. I appreciate his comments and his work.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Under the previous order, there are 5 minutes evenly divided before the vote on the Stabenow amendment.

Who yields time?

The Senator from Michigan.

Ms. STABENOW. Madam President, I appreciate those who are cosponsoring my amendment and have joined with me. I ask unanimous consent that Senator LIEBERMAN's name be added as a cosponsor to the amendment.

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

Ms. STABENOW. This amendment is very simple and very straightforward. What we are saying is, seniors ought to have every possible choice for their prescription drugs, and one of those choices should be under traditional Medicare.

Today, 89 percent of seniors and those with disabilities in our country are under the traditional Medicare insurance plan; only 11 percent are not. We want to make sure, in this amendment, those seniors who are under traditional Medicare—choosing their own doctor, having the confidence to know that regardless of where they live they will have the same premium, the same cost, the same benefit, the dependability of Medicare—that they, in fact, will be able to choose traditional Medicare.

Under every cost estimate we have looked at, in terms of administrative costs, the growth in programs, other kinds of costs, Medicare has always come out less expensive than the private plans that have been compared to it. So, in fact, this does not cost more money, it costs less.

In our proposal, we stay within the \$400 billion parameters by allowing the Secretary of HHS to actually modify the plan to stay within the \$400 billion in the budget resolution. This is no additional cost. This is a question of choice and making sure seniors who, overwhelmingly, choose to stay in traditional Medicare have the opportunity to do so. I ask my colleagues to join with us in creating true choice for our seniors.

Madam President, I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH. Madam President, it is my understanding that CBO has evaluated the information just provided them by the Senator from Michigan, and they are standing by their opinion that her amendment will cost an additional \$50 billion over 10 years. So while the Stabenow amendment does violate the budget, which allocates \$400 billion, it is my understanding the leadership on this side does not want to raise a point of order and would like to take this vote just straight up on its merits.

The provisions of this bill offer Senators a choice between a new way or the old way. I ask my colleagues: Do you want to go the way of Government price control in which you put a bureaucrat between you and your medicine cabinet regardless of Medicare's terrible experience in evaluating market prices on prescription drugs? If you believe this is the way Medicare's future is best provided, then you should vote for the Stabenow amendment.

If you want to try a new way, if you want to see if the marketplace actually works to provide more choices, more cost control, and even better quality and innovation, then you should vote with the bipartisan agreement that has the support of, I believe, a majority of Senators.

This bill presents a choice between the past and the future, between Government, central planning, price controls, and a marketplace that can evolve. But that marketplace will not evolve if Government comes in and

says, on a permanent basis: we are going to be the other choice. I can promise you capital will not follow, and there will be no marketplace developed.

I think seniors of this country are due a prescription drugs package that can pass and that the President will sign. The President is not going to sign a Medicare and Prescription Drugs bill that comprises the Stabenow amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Madam President, prior to 1965, seniors had to go to private insurance companies to get their health care. Half could not find or afford private health care. That is why we created Medicare.

Now we are looking at the opportunity to keep that choice for seniors, plus the opportunity to expand. If they want to be in an HMO, if they want to be in a PPO, they can find insurance in their community. That is terrific. That is their choice. But those who have chosen Medicare deserve the right to pick that choice.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Oregon.

Mr. SMITH. Madam President, have the yeas and nays been ordered?

The PRESIDING OFFICER. They have not.

Mr. SMITH. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 931.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from North Carolina (Mr. EDWARDS), the Senator from Hawaii (Mr. INOUE), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN), are necessarily absent.

I also announce that the Senator from Massachusetts (Mr. KENNEDY) is absent attending a funeral.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 37, nays 58, as follows:

[Rollcall Vote No. 227 Leg.]

YEAS—37

| | | |
|----------|-------------|-------------|
| Akaka | Dayton | Lautenberg |
| Bayh | Dodd | Leahy |
| Biden | Dorgan | Levin |
| Bingaman | Durbin | Lincoln |
| Boxer | Feingold | Mikulski |
| Byrd | Feinstein | Murray |
| Cantwell | Graham (FL) | Nelson (FL) |
| Clinton | Harkin | Pryor |
| Conrad | Hollings | Reed |
| Corzine | Johnson | |
| Daschle | Kohl | |

| | | |
|-------------|----------|----------|
| Reid | Sarbanes | Stabenow |
| Rockefeller | Schumer | Wyden |

NAYS—58

| | | |
|-----------|-------------|-------------|
| Alexander | DeWine | McConnell |
| Allard | Dole | Miller |
| Allen | Domenici | Murkowski |
| Baucus | Ensign | Nelson (NE) |
| Bennett | Enzi | Nickles |
| Bond | Fitzgerald | Roberts |
| Breaux | Frist | Santorum |
| Brownback | Graham (SC) | Sessions |
| Bunning | Grassley | Shelby |
| Burns | Gregg | Smith |
| Campbell | Hagel | Snowe |
| Carper | Hatch | Specter |
| Chafee | Hutchison | Stevens |
| Chambliss | Inhofe | Sununu |
| Cochran | Jeffords | Talent |
| Coleman | Kyl | Thomas |
| Collins | Landrieu | Voivovich |
| Cornyn | Lott | Warner |
| Craig | Lugar | |
| Crapo | McCain | |

NOT VOTING—5

| | | |
|---------|---------|-----------|
| Edwards | Kennedy | Lieberman |
| Inouye | Kerry | |

The amendment (No. 931) was rejected.

Mr. SMITH. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, we are now on the Enzi amendment. I ask unanimous consent that the Enzi amendment be temporarily set aside so that at 4:20 the Senate can proceed to an amendment offered by the Senator from New Mexico, Mr. BINGAMAN.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. I also ask that there be 30 minutes on that amendment equally divided in the usual form.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, I withdraw the second request. So the only request pending, which I think the Chair has ruled on favorably, is that we go to the Bingaman amendment at 4:20.

The PRESIDING OFFICER. That is correct.

Mr. BAUCUS. I thank the Chair.

Mr. President, pending 4:20, when the Senator from New Mexico will offer his amendment, I rise to speak about the rural provisions in the Medicare bill.

This bill has a lot of provisions to help rural America. I am very proud of these provisions. I also wish to compliment the chairman of the committee, Senator GRASSLEY. Over the last year, he and I have jointly co-authored legislation to address the imbalance in Medicare payments that exists between rural and urban areas of our

country. For many rural areas of our country, providing health care services is very challenging given Medicare's current payment rates.

In rural America, Medicare often dominates. That is, most hospitals, doctors and other health care providers receive the lion's share of their reimbursements from Medicare. I know that in many communities in Montana, particularly the smallest communities, Medicare accounts for over more than 50 percent of hospitals total reimbursements. This share is also as high in some larger towns, but certainly more the case in smaller towns.

Rural hospitals are often the major employer in their communities. It is what makes the small town tick. If it were not for the rural hospital, the population in those towns would deteriorate. I have seen that happen in a good number of communities in Montana, where the hospital—fewer than 20 beds in many cases—is the major employer in the town.

Once Medicare payments start to decline significantly, as is the case in many areas, that smalltown hospital has to close up, or converts to what is called a critical access facility and is no longer the full service hospital it was. So it is very important that rural America be adequately reimbursed under Medicare.

In addition to Medicare reimbursements, I believe we have also provided assistance to rural areas with respect to our proposed drug benefit. I believe that the drug benefit outlined in this bill will work for rural America. For example, if private drug-only plans do not materialize, our bill provides for a hard and fast fallback, a Government guarantee for rural seniors. This guarantee is important because many rural States have had an unfortunate experience with Medicare+Choice, the program that currently allows private health plans to participate in Medicare. But because there are so few people in rural America, HMOs and other Medicare+Choice plans, have found it too difficult to operate and have withdrawn.

I do not have the figures with me off the top of my head, but there are thousands of people in rural areas who once had access to a Medicare+Choice plan but no longer have that opportunity because the areas are just so sparsely populated for health plans to work. That is a real concern with respect to the prescription drug benefit we are providing in this bill; namely, will private drug plans, in addition to the preferred provider organizations, want to offer prescription drug benefits in rural America or not? It is a big question, and it is an unanswered question.

We hope they do want to come in and participate. We hope private plans that currently do not now exist will, under the provisions of this bill, when it goes into effect in a few years, want to provide prescription drug benefits for seniors. We hope that many plans want to come in and compete with each other to help reduce costs.

There is no great assurance that these private plans will reduce costs. If one looks at the HMOs, they currently are paid at a higher rate than what Medicare pays for beneficiaries in the fee-for-service program. Some can make a strong argument that these private plans are going to cost more. The theory is that competition will allow them to bring down costs and provide the same benefits for seniors. So it is an unanswered question. People just do not know the degree to which these private plans are going to work. Therein lies the question: What about those parts of America where private plans do not participate? What about those seniors? How can we assure that they are going to get prescription drug benefits? The bill before us tries to address that.

The bill addresses this question by providing for a guaranteed fallback plan. In those parts of the country where there are not two or more competing private drug plans, government-backed fallback plan is guaranteed. Seniors will be able to get the prescription drug benefits under pharmacy benefit manager (PMB), or similar organization that is not required to bear insurance risk. It will only be required to bear performance risk for the administrative costs of providing the benefit. The fallback plan will not bear insurance risk as required of the private drug plans.

The purpose of the fallback plan is to make sure that rural America—in fact, any part of America where there are not two private plans—is served fairly by this prescription drug program.

As I mentioned, the bill includes many provisions to address the current imbalance in Medicare reimbursements between urban and rural America. One provision would correct differences in the standardized amount rate for inpatient hospitals. The standardized amount is higher for urban hospitals than for rural hospitals. The provision says that Medicare should pay the same across the board. Clearly, there will be other adjustments that affect different circumstances and different parts of the country, but the standardized amount would be the same rate for both urban and rural hospitals. That is extremely important to many hospitals in rural areas.

Last year's appropriations bill equalized the standardized amount for a 6-month period. This bill makes that permanent. It is a change that the Medicare Payment Advisory Commission, or MedPAC, has recommended that Congress make. This bill this and other MedPAC recommendations to heart by saying, You are the experts, you know better what is going on than anyone else.

This bill contains a couple of other important MedPAC recommendations. For example, it raises the Medicare disproportionate share threshold for rural hospitals. The Medicare DSH program says if you are a hospital and

have a disproportionate number of people under Medicare who are low income, you should receive extra assistance under Medicare. Our bill raises that threshold for rural hospitals a little higher.

The bill also adjusts payments for hospitals with very low patient volume. We know volume is a big component of whether a hospital is able to make ends meet.

The bill extends the rural home health add-on payment at a level of 5 percent. Home health care is extremely important in rural America.

This bill includes other provisions that not necessarily rural specific. For example, the legislation increases payments to dialysis providers, including those in urban areas, for a 2-year period.

The bill provides desperately needed assistance to urban hospitals that provide a disproportionate share of services to low income individuals. These hospitals are struggling with growing pressures of more uninsured and low income patients. It is not fair for those hospitals that have to bear these costs. They have to provide charity care. In fact, in many respects under the law they are required to. This gives them a bit of a break with these burdens and their nursing shortages.

The bill provides much-needed regulatory relief for both rural and urban hospitals. We have heard from doctors and hospitals that say the carriers and fiscal intermediaries are too heavy-handed; they assume physicians and providers are guilty when they question reimbursement, instead of assuming we are innocent. The regulatory relief measures in this bill address this concern. These provisions are significant and go a long way to assure providers spend less time on paperwork burdens and more time with their patients.

Some may say that this bill does not go far enough to relieve these burdens. A lot of doctors and hospitals administrators will say: Gee, why all this Medicare paperwork? We want to spend time with our patients. Nevertheless, the regulatory provisions of this bill will reduce paperwork and unnecessary regulation.

I realize there are a number of provider provisions—with respect to doctors and hospitals and other providers—that are not addressed in this bill. These provisions include payments under the Medicare physician fee schedule, which will be cut in 2004 through 2007 unless further congressional action despite an additional \$54 billion in the bill we passed earlier this year. We recognize the need to address these impending cuts in the future. Physician's fees are projected to drop significantly. We cannot address that in this bill. We do not have the money. That is a problem we will have to face in 2004. I alert Senators, that will be expensive. We will have to deal with it.

There are also Senators who want to address what is called IME, or indirect

medical education. This is the special payment adjuster under Medicare for teaching hospitals. It is now currently reduced to its lowest level ever. That is, teaching hospitals are receiving less to help train physicians across the country. That is a concern many have. We are going to try to deal with that as best we can as this bill progresses.

Nursing home payments are not addressed. Many Senators have talked about addressing some of the problems facing nursing homes. They, too, experienced a sharp reduction in payments over in 2003. This list of payment provisions is not limited. There are several other provider provisions about which many Senators have raised concerns.

Our ability to deal with these additional issues is limited. Why? Because this is a \$400 billion Medicare package. The fact remains, this is a package of relatively sparse drug benefits. Yes, \$400 billion sounds like a lot of money, and it is. But \$400 billion extended over 10 years, means that we have to carefully consider what the amounts should be for the deductible, copayments, and the premiums. The numbers are OK, but they are not great.

I don't want to oversell this bill or over promise. This legislation is a step in the right direction. This is a good first chapter. It is a start in providing prescription drug benefits for seniors. We only have \$400 billion so we have not been able to address these other provisions. We would like to. We would like to find a way to deal with them. But at this time, the dollars are simply not there.

I might add, we will do what we can in future days, weeks, and months to try to address these concerns.

I know the chairman of the committee, Senator GRASSLEY, wants to work with our colleagues to address these provisions and also provide a fair deal for rural, as well as urban, folks in America. We want to address future geographic inequities with respect to the drug benefit. The fact is, rural States are very concerned if we enact this prescription drug benefit, are going to come out on the short end of the stick. More federal money will end up going to go to urban seniors. That will cause a great problem.

At the same time, seniors in urban areas are afraid the money will go to the rural areas, that the urban cities will end up on short end of the stick. The fact is, we do not know how it will work. We just don't know. Senator SNOWE offered an amendment in the Finance Committee for a study to address possible geographic inequities in drug spending across the country. She later amended it, made it a little stronger, to say that HHS will have the discretion to address any geographic inequities. There may be an amendment on the floor to require the HHS Secretary to address the inequities.

It is a point about which we are all very sensitive. We are trying to find a way to make this geographic adjustment process work. Geographic adjust-

ment for drug spending has never been tried before. It is uncharted territory. We just don't know. It probably makes sense the Secretary have discretion.

That is a short summary of some of the rural provisions in the bill. I see the Senator from Texas is on the Senate floor. Does the Senator from Texas wish to speak at this point?

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I appreciate the Senator from Montana giving me a chance to say just a few words.

May I inquire, my understanding was Senator BINGAMAN was going to be coming at 4:20 under a previous agreement to speak, but there also was a possibility I might be allowed to continue a while longer, perhaps 20 minutes.

The PRESIDING OFFICER. Is there objection to the modification of the agreement?

Mr. BINGAMAN. Mr. President, I have no objection to the request of the Senator from Texas who asked if he could be allowed to speak for 15 or 20 minutes before we begin my amendment. If that is not a problem for the manager of the bill, I have no objection.

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

Mr. CORNYN. I express my appreciation to the managers of the bill and Senator BINGAMAN for his courtesy.

This is obviously a critical issue that confronts the Senate, one this body has talked about for a long time. It appears we are on the precipice of actually delivering what many of us have campaigned on, on both sides of the aisle, in previous elections.

Medicare has been a successful program for the last 30 years, and it has served our seniors well. But it faces major challenges. Obviously, we are all interested in strengthening Medicare so it will continue to be a program that will serve our children and grandchildren as it has our parents and grandparents. Medicare was created in 1965 and reflects the state of health care in that year. While the world has changed and medicine has changed, Medicare has not changed. It is time to improve and strengthen Medicare so it can serve the needs of Americans of this generation and the next, and can also be within our fiscal constraints.

Medicare is stuck in 1965, and so are its beneficiaries. Medicare's promise falls far short when its recipients suffer from outdated and inadequate benefits, limited protection against rising medical costs, or a stodgy Government plan that cannot deliver responsive medical services or ensure high-quality health care.

While health insurance has followed the demands of the free market, Medicare still lacks catastrophic protection or full coverage of many preventive benefits in a comprehensive outpatient prescription drug benefit.

One of the critical improvements included in this bill is immediate assistance, in the form of prescription drug

coverage, for those seniors who cannot currently obtain it or who do so only at great economic hardship and great personal hardship. I have supported the principle of a prescription drug benefit from day 1 for the seniors who need it. I am proud to reiterate my support here today.

Having said that, I have significant concerns about the legislation that is before this body—some aspects of it, significant aspects of it. While a prescription drug benefit and expanded treatment choices will help America's seniors, this bill falls substantially short of President Bush's framework for reform. If we endorse this legislation without real and meaningful reform, we rush to satisfy political interests rather than take the time to form sound policy, and we do a great disservice to the Medicare beneficiaries who depend on this coverage, to our constituencies, and to the future generations who will have the financial burden to pay for it. Ultimately, if we do not take care, we could do more harm than good.

According to estimates of the Congressional Budget Office, this plan will have unintended ramifications for Americans. It will force nearly 40 percent of retired Americans who currently have prescription drug benefits under private plans onto taxpayer-paid plans that would be provided under this bill. The CBO, the Congressional Budget Office, predicts that only 2 percent of seniors will actually choose the only vehicle for reform provided for under this bill, that of the preferred provider organizations, the PPOs, while the rest will remain in Medicare basically as it currently exists with a prescription drug benefit added, hardly what we could call true reform.

We should not fool ourselves. What we are actually providing seniors under Medicare, and through this bill, is actually very different from what Members of Congress receive. Under the Federal Employees Health Benefits Plan, all of us in this body, along with 10 million Federal employees, can enroll in a number of flexible preferred provider organizations. The plans we can choose as Federal employees do not have restrictive price caps, and they provide for more choice. As a result, those of us who work for the Federal Government can obtain better coverage and treatment than the vast majority of our constituents. This disparity, I believe, should not be tolerated under this plan, especially one that charges under the banner of reform.

Price controls are a recipe for long-term disaster. The best determiner of price in a product is the free market, not government bureaucrats sitting in darkened cubicles wearing green eyeshades. My other concern is that this purports to be a universal entitlement, based on nothing like what we have talked about in many of our campaigns, which is actually need. It will provide a prescription drug benefit to millionaires, including Members of this

body who just do not need it. I question the morality of any proposal that would take the hard-earned money out of the pockets of truck drivers, schoolteachers, police officers, small business men and women and single moms, to subsidize a prescription drug benefit for people who are well to do.

When it comes to health care, I believe the proper role of government is to protect the freedom of all people to act as they see fit to maintain and improve their health care. Today, millions of Americans suffer from chronic diseases that are for the most part preventable. Our Nation spends about \$1.4 trillion a year on health care—more than any other country in the world—and chronic diseases account for roughly 75 percent of those health care costs. Preventing disease before it happens is better, more humane, and less expensive than curing disease after it manifests itself, and prevention can lead to a far better quality of life. If Medicare is to adapt to the demands of a new populace, it must become a system refocused on the importance of preventive care.

I strongly believe that real positive change in our Medicare system must begin with the foundation of individual responsibility and the choices that can only be provided by the free market—not by a government mandate.

We must not offer up a short-term legislative answer that plays politics with people's health and the needs of future beneficiaries. We should not tinker only around the edges and call it reform.

As we work over this week and next to produce a solution to this challenge that lies before us, we cannot allow ourselves to believe our striving will fail, and we must not convince ourselves we have already succeeded.

In conclusion, let me say it is my most ardent hope that this bill, which I know was produced by great effort of the staff and on a bipartisan basis by the Senate Finance Committee, can be improved and that the improvement will allow us to make sure the benefit is targeted to those seniors who actually need the help and not millionaires, thereby having the wealth transferred out of the pockets of hard-working Americans to pay for a prescription drug benefit for millionaires and others who are well to do.

Second, let us make sure we don't crowd out private dollars that are currently paying for prescription drug benefits for many retired persons which they have negotiated under the terms of their retirement or pension plan. Right now up to 40 percent of those dollars will be chased off and the Federal Government—in other words, the taxpayer—will step forward and fill that gap. That is something we should not allow.

Third, if this is truly going to be reform, it has to be something more than business as usual.

What concerns me quite a bit is on the one hand the OMB estimates that

some 40 percent of seniors will opt for the true vehicle for reform—the PPOs, the preferred provider organizations—but, on the other hand, another agency of the Federal Government, the Congressional Budget Office, says No, it won't be 43 percent. It won't be 40 percent. It will be 2 percent.

In other words, if the Congressional Budget Office is right, we will not have accomplished what the President has asked us to do and what many in this institution believe is so important; that is, true reform.

It is my hope and prayer we will be able to make the necessary adjustments to this very good start. But there are some very grave concerns that I and others have about the bill as it currently exists.

In a tight budget, I hope we do not vote for what is by most conservative estimates a \$400 billion new entitlement on top of \$2.2 trillion the Federal Government commits to nondiscretionary entitlement spending each year, unless we make sure it is absolutely necessary and targeted to those who need it most, and that it does not supplant other private insurance and other measures designed to provide prescription drug coverage for our seniors.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

AMENDMENT NO. 933

Mr. BINGAMAN. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 933.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries)

On page 120, between lines 16 and 17, insert the following:

“(I) ELIMINATION OF APPLICATION OF ASSET TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section made on or after October 1, 2008, such determinations shall be made without regard to subparagraph (C) of section 1905(p)(1) (to the extent a State, as of such date, has not already eliminated the application of such subparagraph).”

Mr. BINGAMAN. Mr. President, this is a very straightforward, simple amendment that deals with a problem that is buried in this legislation and

which really needs to be dealt with. That is the so-called assets test. My amendment would eliminate the assets test beginning in the year 2009.

The first obvious question everyone should be asking is, What is the assets test? The assets test is as follows: The bill provides a more generous set of benefits for low-income individuals and low-income couples. That is as we intend.

I think all Members of the Senate recognize that those who have the least in the way of income really need the most help in paying for their prescription drugs, particularly when you are dealing with seniors who are not, in most cases, out in the workplace able to increase their income. We believe the proper, the humane, and the compassionate thing is to provide this greater level of subsidy for low-income individuals.

In particular, we look at those individuals with incomes up to 160 percent of poverty. That is the figure we have in this legislation. That translates into, I believe, what we are talking about. A couple with an income of perhaps \$17,000 or \$18,000 a year would qualify, and if they had any more income than that they would not qualify for this higher level of subsidy.

The bill also provides that if a low-income individual has as much as \$4,000 in assets, that individual is not entitled to that subsidy in the same way others would be.

For example, if you have a 70 or 75-year-old widow who is receiving \$5,000 a year in income or \$6,000 a year or \$8,000 in income and that widow also has \$1,000 in U.S. savings bonds, and a car that has a blue book value of \$3,100, then that widow is not entitled to the full benefit unless and until she goes out and either sells the savings bonds or sells the car or somehow or other impoverishes herself to be able to demonstrate she does not have assets worth \$4,000.

This is a test that was put in the law many years ago. It is one that adds great complexity to the law. In fact, a major effect of this assets test is to discourage a great many low-income individuals from even applying for the increased benefit that is provided for in this legislation because the requirements for reporting, filling out forms, getting blue book values on your automobile—these are complicated requirements that discourage people from applying across the board.

I also point out that under this assets test, not only is it \$4,000 for an individual—so if you have \$4,000 worth of income, of assets, as a widow, you fail the assets test—but if you are married, it is then \$6,000. A lot of the Members of this Senate and the Congress have given speeches about what a terrible thing the marriage penalty is. Here is another marriage penalty that is in the law we are dealing with today. This is a penalty which says, if you get married, your ability to hold on to assets and still get this full benefit is reduced.

You cannot hold on to as many assets. You can only hold on to \$6,000 as a couple whereas you could hold on to \$4,000 as an individual.

In my view, the justification for this assets test has long since gone away. The reality is, if people are unable to work, as most seniors are, unable to increase their income, if they are low-income individuals, and if they have very substantial prescription drug costs, they need the assistance we are providing in this legislation—or trying to provide in this legislation—and we should not take that away from them by virtue of their having \$4,000 worth of assets as an individual or \$6,000 worth of assets as a couple.

Let me elaborate on this a little bit more. There are about 40 million seniors and people with disabilities who depend on Medicare who could benefit from this prescription drug coverage we are talking about in this bill, and this assistance is particularly critical for those low-income individuals. Here we are talking about 14 million beneficiaries who have incomes less than 160 percent of poverty. Many of those individuals are in the State the Presiding Officer represents. Many of those individuals are in my State of New Mexico.

The bill provides a significant benefit to those low-income seniors and individuals with disabilities, but it does so only if they do not fail the assets test. I do not know the exact figures, but the Congressional Budget Office estimate is that 21 percent of Medicare beneficiaries who would otherwise qualify for this low-income benefit in fact will be denied that full benefit because they fail the assets test.

In fact, for those below 100 percent of poverty, if they fail the assets test, their cost sharing is increased, under this bill, by 400 percent. For those between 100 and 135 percent of poverty, the assets test causes their cost sharing to increase by 200 percent.

I believe strongly that in the year 2009—which is what I have in my amendment—we should eliminate the assets test. I would propose we do it earlier, frankly, but I am informed that the Budget Committee has calculated the cost of the bill in such a way that there is no funding available for us to do anything such as eliminate the assets test before the year 2009. So I have crafted the amendment so that it would become effective in the year 2009.

In addition to protecting low-income beneficiaries below 135 percent of poverty from much higher costs, much higher copays due to this assets test, it should also be noted that the assets test significantly increases the paperwork burden on seniors and on individuals with disabilities.

While the underlying bill provides physicians and other health providers with regulatory relief—and that is one of the things we keep talking about when we try to describe the benefits in this bill—I fear the bill will signifi-

cantly complicate the ability of Medicare beneficiaries to receive prescription drug coverage, particularly low-income individuals. They may need—I said this in the committee during our markup, and I believe it is not a totally facetious statement—they may need an accountant or a lawyer just to figure out the paperwork having to do with this assets test and how they can access these benefits.

We should not be putting people to the choice of selling their car or liquidating their U.S. savings bonds in order to get the benefits of this bill. There are a great many low-income individuals who have very high prescription drug costs. That is a very unfortunate fact but one we are trying to come to grips with here.

Under the bill, if they fail the assets test, their copay requirement is 10 percent until they hit the so-called doughnut portion of the bill, which means essentially \$4,000 of prescription drug expense in any given year; and then for the next \$1,500 or \$1,800 beyond that, they pay a 20-percent copay. If you have high prescription drug costs, a 20-percent copay is substantial. If you have high prescription drug costs, even a 10-percent copay can be substantial if your income is extremely low. And that is the group we are talking about here.

So, Mr. President, I hope my colleagues will support the amendment. It is done in a responsible way. It is not drafted in such a way that it would take effect immediately. It takes effect in the year 2009, when we are advised by the Budget Committee funds will be available to pay to eliminate this assets test. It clearly is the right thing to do. It is the humane thing to do if, in fact, we are serious about helping low-income seniors deal with this very substantial burden. We should adopt this amendment and eliminate the assets test as soon as we can afford to do so. And the Budget Committee tells me that is in fiscal year 2009.

So I hope very much colleagues will support the amendment.

Mr. SPECTER. Mr. President, I have sought recognition to express my support for increased funding for rural hospitals. Pennsylvania is a geographically and demographically diverse State, and the health care needs of the communities across the Commonwealth differ significantly. But there is one constant—access to appropriate health care is critical, and if we are not prudent in making wise health care policy decisions now, we may jeopardize our citizens' ability to get the right care, in the right setting, at the right time.

We must be aware of the pressures and challenges that constantly weaken the foundation of the health care system—the medical liability insurance crisis, inadequate State and Federal reimbursements, workforce shortages, growing uncompensated care costs, rising costs of technology and pharmaceuticals, bioterrorism planning and

training, and a growing elderly population. As we look at restructuring a segment of the Medicare Program, we have the opportunity to strengthen that foundation. Improving our prescription drug benefits will not help the senior citizens of this country if health care providers cannot meet their needs.

We must also remember that our actions here in the Senate and by our colleagues in the House have implications not only for the quality and stability of our health care system but for our economic health as well. A recent study completed by the Penn State Cooperative Extension and the Pennsylvania Office of Rural Health shows that the State's hospitals are the largest component of the health services sector, generating more than \$33.9 billion to the State's economy. This includes 260,000 full- and part-time jobs, a payroll exceeding \$9.3 billion, and a ripple effect that provides another 179,400 jobs and \$5.4 billion in additional employee compensation. In many counties, the hospital is the No. 1 employer. Furthermore, the State's research hospitals have been identified as an integral component of biotechnology clusters, serving as an engine of growth in the new economy.

Given all of these dynamics, we must support a legislative plan that adequately funds hospital and health systems. This plan must recognize that our rural communities face a unique set of challenges because they are often the only provider of health care in a vast geographic region and they have greater difficulty recruiting health care workers and physicians in today's health care climate. Such a plan should also include two major rural provisions dealing with the standardized rate amount and a change in the labor component to 62 percent. The standardized rate amount will allow rural hospitals to receive a Medicare standardized payment rate equal to the higher rate paid to urban areas. The adjustment of the labor component from 71 percent to 62 percent for rural hospitals will allow rural hospitals, which traditionally have low labor costs, to base a larger portion of their Medicare reimbursement on nonlabor provisions, thereby receiving a higher reimbursement from Medicare.

I urge my colleagues to join in making sound health care policy decisions to ensure we are strengthening the foundation of our health care delivery system in those areas in which it is most vulnerable.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

Mr. FRIST. Mr. President, I wish to take a few minutes to address the Pre-

scription Drug and Medicare Improvement Act of 2003 in a very basic way, and that is to answer some of the questions I have received over the last several days since we have captured much of the attention both of the media as well as constituents around the country who realize we really are going to pass very significant, very important legislation that will affect their lives, that will affect the lives of seniors, individuals with disabilities, and that will affect the lives of future generations. And this will happen in the next 12 to 13 days.

It goes back to the question of, Do we really need to change? Are things really that different that they demand the sort of response we are putting forward where we talk about strengthening and improving the Medicare Program overall and at the same time providing prescription drug coverage for seniors and individuals with disabilities that is not being provided today, and do it in a way that can be sustained over time, recognizing that we will have a huge demographic shift of seniors over the next 30 years as a product of the baby boom following World War II. That fertility curve, that baby boom moving through the system begins to hit about 2007, 2008. That is when the curve moves through.

For the next 25 years after that, we will see this huge explosive growth in the number of seniors with fewer and fewer workers actually paying into the system.

We have now been on the bill Monday, Tuesday, and Wednesday, after having over 30 hearings on Medicare over the last several years and several hearings this year specifically on prescription drugs and Medicare modernization in the Finance Committee. We have done it in a very systematic way, in a bipartisan way that I think captures the very best of what this institution is all about, recognizing that we do not know all of the answers, we cannot cure all of the problems.

We have to be very careful not to overpromise because everybody wants as much health care resources as possible, so we cannot overpromise. As I say, we need to reform the system in a way that does not just respond to the needs of today but responds to the next year, 5 years from now and 10 years from now. Since we cannot do it perfectly now, we have to do it in a way so that the system is flexible and allows us to adapt appropriately.

Working on a bipartisan basis, the goal is to deliver a secure Medicare Program that is comprehensive and, at the same time, offers maximum choice with that increased flexibility and that much-needed prescription drug coverage which seniors do not have today through the Medicare Program.

I look forward to the continued debate over the next 10, 11 days on how we collectively determine how best to accomplish those goals. I am confident we will be able to cull the very best ideas from both sides of the aisle to pass a responsible and effective plan.

As I mentioned, I want to limit my comments today to about how medicine, science, and health care delivery has evolved and, indeed, how that evolution, which has been very rapid in terms of breakthroughs in science, which I have been privileged to watch and participate in as I was in the field of medicine for 20 years before coming to the Senate—it has been miraculous in so many ways. When I close my eyes, I see my patients with artificial hearts I had the privilege of implanting, and with the heart transplants I was blessed to do on a weekly basis or even more often. I was involved in not the whole period since 1965 when Medicare began, but shortly thereafter, I was in the active practice of clinical medicine over that period of time.

If we just look at the last 10 years, life expectancy has increased by around 2 to 3 years, and if we look at the last 40 years, going back to about 1960, life expectancy increased 10 years in that period of time since Medicare was begun.

Death rates from heart disease have been cut in about half over the period since Medicare began. Heart disease happens to be the field in which I specialized.

If we look at the field of cancer, whether it is prostate cancer, breast cancer, or colon cancer, because of new treatments, new medicines, and new diagnostic tools, we have seen markedly increased patient survival rates. At the same time, we have seen these great medical breakthroughs in the health care delivery system, the private health care delivery system—not Medicare—but the private health care delivery system has evolved and has responded.

The problem is that the underlying Medicare system itself has not evolved. In fact, there has been very little change in the Medicare system since 1965. So we have all these great medical advances and advances in health care delivery over time which has skyrocketed, with improved advances throughout, but we have a Medicare system that has changed very little. It is this gap, this difference between the great breakthroughs in medicine, science, and health care delivery and the pretty much nonchanging Medicare system. That gap is what we are attempting to fill, to respond to as we go forward.

Medicare was designed to respond to an acute illness. Let's say you are healthy and all of a sudden you have a heart attack and you have a good response to that heart attack in hospital treatment, and it worked pretty well as long as that was what health care delivery was.

Today, the situation has changed markedly. Preventive medicine today is exponentially more important than in 1965. Why? Because we understand how to prevent disease, how to maintain health. In 1965, we did not fully understand the nature of the science of preventive medicine. It simply was not

developed in 1965 to the degree it is today. Yet we have a Medicare system which has—I came close to saying almost no preventive care is provided in Medicare today. That is a little bit of an overexaggeration because we have to legislate that, yes, Medicare does cover mammography. Almost every one of these procedures has to be legislated, and with so many advances coming through quickly, we cannot keep up.

There is very little preventive care in Medicare today. Yet we all know how important it is if we look at managing one's health today, maximizing one's health.

In the 1970s, health care responded to acute episodic illnesses. Today it is preventive health care, maintaining wellness, management of chronic disease on an outpatient basis, using medicines, but Medicare has not changed very much.

I will give a couple of examples. Again, the goal is health care security for seniors. If you see a senior, you want to be able to say: The Government is helping you with health care security, and health care security means we have to include prescription drugs.

I mentioned Medicare lacks good preventive coverage. It also lacks the wellness care in chronic disease management. For example, Medicare does not cover cholesterol screening. If we look at heart disease, cholesterol is important. Yet Medicare does not cover cholesterol screening.

Medicare does not cover an annual physical examination today. I do not know if it has to be every year or every 18 months, but the point is, systematic regular examinations, if you are going to pick up that cancer when it is small or that heart disease before it becomes a massive heart attack, you can do it through annual physical exams, but they are not covered under Medicare.

Medicare does not protect at the extreme end, what we call catastrophic. That means if you are sick enough, if you have a lot of out-of-pocket expenditures, Medicare has no limit to that. Today if you have a catastrophic illness, there is no upper limit. A lot of people do not realize that.

The one issue we talk a lot about, because it is probably most dramatic, is that Medicare does not at all cover outpatient prescription drugs.

Thus, we have gaps in coverage for seniors. We are promising them health care security which they deserve, and yet we have these huge gaps in coverage which have been created since 1965. It is our obligation, our responsibility to respond, and, thus, over the next 12 days we will be putting together a bipartisan plan—though we do not know all the answers—we will be putting together the very best of what we do know to respond to these needs.

Today, on average—and a lot of people do not understand, or they were not aware of this, so it is important for us to keep saying it—Medicare covers

right at about half of what a senior's medical care expenses are. Most think it covers 80 or 90 percent. If one is not yet a senior, it is important for them to know what their Government is doing for them now is to cover only about half of the expenses. Again, most people are not aware of that.

The response to that is that seniors and individuals with disabilities try to fill those gaps on their own, sometimes successfully, and many times not. They try to do it through Medicaid. They try to do it through private supplemental insurance programs, only to find that they are hit with these skyrocketing premiums that are growing 10, 15, 20 percent a year at this point. Or they find that their employer on whom they were depending is scaling back on the benefits that they once had when they were working full time.

I say all of this because it is important for people to understand why we are aggressively moving ahead in the way we are to develop a strengthened and improved Medicare plan.

I mentioned the lack of prescription drugs. If we look at aging, our population over the age of 65, we know prescription drugs become even more important than they are under 65 years of age or under 50 years of age or under 45 years of age, and that is new. It is really within the last 30 years that these medicines have become so important. Thus, it is our obligation to strengthen and improve access to prescription drugs.

I have had the privilege to observe a lot of this as a physician, and I will give a couple of examples. Over the past 3 decades—remember, Medicare started in 1965—the death rate from hardening of the arteries, or atherosclerosis, the underlying pathology within the heart, has declined by 74 percent. Deaths from ischemic heart disease—ischemic is low blood flow where the heart is not getting enough oxygen and blood, and that is what causes a heart attack, hardening of the arteries, myocardial infarction, heart attack—death rates have fallen over the last 30 years by 60 percent.

People ask why. There are lots of reasons, but I would say one of the major reasons is medicines today, that we are treating high blood pressure earlier; we are treating congestive heart failure earlier before these deaths from ischemic and other heart disease occur. Medicines that were not around 30 years ago are the beta blockers. It actually makes the heart so it does not beat so hard. If it is not beating so hard, it does not consume as much energy and does not need as much oxygen. Therefore, low blood flow to the heart does okay. Other drugs called ACE, A-C-E, inhibitors, the medicines, in large part, have explained this increasing survival fall in mortality.

Over the last 30 years since Medicare began, death rates from emphysema, or lung disease—a type of lung disease called chronic obstructive pulmonary

disease, emphysema, is one of those two types—have fallen by 60 percent in large part because of the use of anti-inflammatory medications—they decrease the inflammation in the lungs—and also a group of drugs call bronchodilators, which dilate those little bronchial air waves in the lung. The point is, it is these medicines that in large part explain this improved health and the improved treatment of emphysema.

I have a couple of books with which I wanted to illustrate my point. Nearly 400 lifesaving drugs have been produced in the last 10 years. Meanwhile, there are over 600 medicines under development right now by the Nation's pharmaceutical research companies to treat diabetes, heart disease, cancer, stroke, and peripheral vascular disease.

I mentioned these books. This is called the PDR, the Physicians' Desk Reference, for pharmaceutical specialties and biologicals for the physician's desk. Every physician in the country uses this on a regular basis because it allows them to look up individual medicines. It gives the descriptions, the side effects, and the contraindications. No matter how smart one is or how much time one spends with it, there is no way to remember all of these drugs or everything in the book, although some people may be able to.

The point is, this book was printed in 1965. This is the year Medicare was actually passed and then implemented. That was over 30 years ago. Again, this book has 1,060 pages in it. The type is pretty small. It is just medicine after medicine. When I see this, I am kind of glad I do not have to know all of that right now because there is so much in it.

This PDR is the 57th edition, and this one is from 2003. It is pretty interesting to me because this first book is when Medicare started, and this other book is where we are today. Today's book is a little bigger but is a lot thicker, and instead of having 1,060 pages in it—these are not all lifesaving drugs but all drugs which have a real importance in terms of treating and quality of life—this book has 3,500 pages in it. I wish I could show this to the Chair, but the type in this new book is about half the size of the type in the old book. So the truth is, it is about 6,000 pages.

The point is, medicines make a difference. They made a difference in 1965. They really make a difference today. Seniors do not have access to these through our Medicare system in either case. Great advances, and our Medicare system has not changed. It does not recognize that as we go forward. That is why we are here. I want to make this case of why we are here and why this is so important today that the health care system, the delivery system, has markedly improved with great scientific advances, and Medicare is not capturing it today. Our seniors deserve for those to be captured.

Next month does mark the 38th anniversary of the launch of Medicare. On July 30, 1965, President Johnson traveled to Independence, MO, to sign the

bill into law. President Truman, who had initiated the drive for health care security for seniors about 20 years earlier, was on hand to receive that first Medicare card. President Johnson, upon signing that historic legislation, told the assembled lawmakers in 1965:

The benefits under the law are as varied and broad as the marvelous modern medicine itself. No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents . . .

Nearly 40 years later, we have an opportunity to realize this noble vision. Before the end of next week, the Senate will have the opportunity to pass legislation that does provide prescription drug coverage for our seniors, that does protect seniors and gives them health care security by giving them greater choices so that they can choose the health care coverage that best meets their individual needs.

I believe future generations will judge us by the choices we make over the next several days and at the end of next week, whether we chose to act responsibly, recognizing our obligations to strengthen and improve the system, or whether we chose just to talk about it, the same rhetoric, something that we should do. My position is clear; now is the time to act. I am delighted we are acting in a bipartisan way. Now is the time not just to tinker and play around the edges, but it is time to truly transform the system.

We have a responsibility to provide our seniors with a system that works, that indeed gives them health care security, and now is our opportunity to deliver it. It will require us to focus on the big picture. It will require us to focus on the future. It will require us to focus on our fellow citizens, whom we are so privileged to represent.

The PRESIDING OFFICER (Ms. COLLINS). The Senator from Utah.

Mr. HATCH. Madam President, I compliment the distinguished majority leader for his excellent set of remarks today. The comparison between the two PDR books is startling. Anyone who looks at it has to admit we have come a long way since 1965.

This bill was a great addition to the health care for our people. It could not have happened without the distinguished Senator from Tennessee, our leader, plus the distinguished Senator from Iowa, Senator GRASSLEY, and the distinguished leader from Montana, Senator BAUCUS. I appreciate having a doctor in the Senate. As a former medical liability defense lawyer, I have to say I have always respected Senator FRIST very greatly, but nothing comes close to how much I respect him as a physician, as somebody who cares for people and has given so much of his life to healing people.

I am very grateful to have heard these remarks today.

Mr. FRIST. I thank the Senator.

AMENDMENT NO. 933

Mr. HATCH. Madam President, I will only take a few minutes, but I rise in opposition to the Bingaman amendment.

First, let me make one thing clear, and perfectly clear:

The assets test in S. 1 is the same assets test used for determining eligibility for the qualified Medicare beneficiaries, QMBs, specified low-income Medicare beneficiaries, SLMBs, and qualified individuals, QI-1s.

S. 1 provides a generous low-income subsidy for those who are below 160 percent of the Federal poverty level. Currently, in order for some individuals under 160 percent of poverty to receive limited Medicaid protections, they must meet both an income limit and an assets test.

In S. 1, we simply follow these same rules in order for low-income beneficiaries to receive assistance with their prescription drug coverage.

By including the Medicaid assets test for Medicare prescription drug subsidies, we are providing beneficiaries with seamless health coverage. We are not confusing beneficiaries and we are not adding additional administrative burdens to States.

Let me give you some background on the current assets test included in the Medicaid program.

Qualified Medicare beneficiaries are individuals below 100 percent of poverty. In 2006, the annual income limit is \$9,670 for individuals and \$13,051 for couples. QMBs are allowed to have assets below \$4,000 for individuals and \$6,000 for couples.

Specified low-income Medicare beneficiaries and QI-1s are those with incomes between 100 percent of poverty and 135 percent of poverty. In 2006, the annual income limit is \$13,054 for individuals and \$17,618 for couples. SLMBs and QI-1s are allowed to have assets below \$4,000 for individuals and \$6,000 for couples.

Beneficiaries between 136 percent and 159 percent of poverty will have annual income limits of \$15,472 for individuals and \$20,881 for couples in 2006. Beneficiaries between 136 and 159 percent of poverty would not be subjected to assets tests.

Current law establishes resource limits for low-income elderly or disabled individuals. Let me emphasize, this is not a newly added restriction on certain low-income Medicare beneficiaries. However, current law also provides States with the flexibility to choose to disregard all or part of these resources.

The Bingaman amendment, which eliminates the Medicaid assets test limits would add significantly to the number of eligible beneficiaries.

A study prepared for the Kaiser Family Foundation estimates that as many as 11 million individuals would be newly eligible for low-income assistance if the assets test were eliminated. I have no idea how much that will cost but it will be expensive.

In addition to increasing the Federal cost of the bill, this amendment would impose a significant, new, unfunded mandate on States, which must pay a share of Medicaid benefits by paying for the dual eligible beneficiary's liability for premiums, deductibles, and coinsurance.

Also, some States may experience an additional administrative or financial impact from potential program redesigns because, in some cases, States link eligibility for their state-only programs with the eligibility requirements for these special categories of the dually eligible.

S. 1 includes a provision to require the GAO to conduct a study and make recommendations to Congress by 2007 regarding the extent to which drug utilization and access to covered drugs differs between qualifying dual eligibles who receive subsidies and individuals who do not qualify solely because of the application of an assets test.

This amendment will not only cost money, it will cause confusion. I urge my colleagues to defeat the Bingaman amendment.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, the underlying bill, the bill from the Senate Finance Committee to provide prescription drugs for the improvement and strengthening of Medicare, provides a very generous low-income subsidy for those who are below 160 percent of the Federal poverty level. For some of the seniors below 160 percent of the Federal poverty level, there is no asset test.

Currently, in order for some of the individuals below 160 percent of poverty to receive the most generous low-income subsidies, there is an asset test and there ought to be. The crafting of this bill provided everyone a conscientious effort and decision to make possible this legislation and to make it well balanced. There were extra dollars and the decision was made to fill in the coverage gap rather than eliminate the assets test. There is no limitless amount of funds for this prescription drug benefit.

We are in a position of zero sum gain. We have \$400 billion under the budget to work with. This bill works to do the most for all Medicare beneficiaries. Seniors with incomes below 160 percent and who do not pass the established asset test still receive a very generous low-income subsidy. These beneficiaries will not have a gap in coverage.

This amendment by the Senator from New Mexico will add unknown costs to the current bill. It will change the structure of the bill and affect the current Medicaid Program by adding costs that are very substantial in the out-years. Therefore, when we vote tomorrow on the Bingaman amendment I hope we will have a strong vote against it. Not that I denigrate in any way the intentions of the Senator from New Mexico. I know him to be a very conscientious Senator, to do well, and to

be very thoughtful in his approach. Obviously, on this point he has some disagreement with the product of our committee that was voted out 16 to 5 last Thursday.

But, here again, we have to do the most we can within the \$400 billion that the Budget Committee has given us to work with for providing a prescription drug benefit to our seniors as part of improving and strengthening the Medicare Program overall. We could have put more money into the asset test as he indicates he wants to do now with this amendment. We chose, as I indicated before, to help more people with the same amount of money by filling in the gap or, as some people would say, the donut hole.

We believe we should put as much effort as we can into taking care of that problem because, to help the very same people Senator BINGAMAN wants to help, we have put a lot of resources into the effort of prescription drugs for seniors, for those below 160 percent of poverty.

So, once again, I urge the amendment be defeated when we vote on it tomorrow.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. GRASSLEY. The first unanimous consent request is that the Senate proceed to a period for morning business.

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

COUNCIL ON FOREIGN RELATIONS INDEPENDENT TASK FORCE ON BURMA

Mr. MCCONNELL. Madam President, the Council on Foreign Relations Independent Task Force on Burma today released a report entitled: "Burma: A Time for Change". I am pleased to have had an opportunity to serve as a member of the Task Force along with my colleagues, Senators LUGAR and FEINSTEIN, and Representative LANTOS.

The report describes the State Peace and Development Council's repressive rule in Burma, and makes a number of recommendations including: increased humanitarian assistance for the people of Burma through NGOs, and in consultation with the NLD and other groups representative of a multiethnic Burma; an import ban on goods produced in Burma, visa denials to leaders of the military regime and its political arms, and the freezing of assets abroad; U.S. leadership in urging the United Nations Security Council to adopt a resolution that demands the immediate

release of Suu Kyi and all other political prisoners, and to hold an emergency session to impose other sanctions on Burma; U.S. leadership in working with our allies and Burma's regional neighbors to bolster support for the struggle for freedom and the rule of law in Burma; no certification for Burma on narcotics cooperation as it has "failed demonstrably" to curtail drug production, drug trafficking and money laundering; and increased assistance to refugees fleeing Burma in Thailand, India, Bangladesh, and China.

I thank the council for the timeliness of the task force, and all the members for their participation.

Madam President, I ask unanimous consent that a copy of the executive summary of the report be printed in the RECORD.

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

BURMA: A TIME FOR CHANGE

EXECUTIVE SUMMARY

On May 30, 2003, the Burmese military regime orchestrated violent attacks by pro-government militia on Aung San Suu Kyi, the leader of the National League for Democracy (NLD) and her supporters as they traveled outside Mandalay. At least four of her bodyguards were killed as well as a significant number of others. She has been held in custody since then. Following the attacks, the regime arrested more than 100 democracy activists, imprisoned at least a dozen, shut down NLD offices across the country, and closed schools and universities. This is the bloodiest confrontation between Burma's military rulers and democracy supporters since 1988, when the government suppressed a popular uprising against the regime and thousands were killed.

Burma has been ruled for more than 40 years by a succession of military regimes that have systematically impoverished a country once known for its high literacy rate, excellent universities, and abundant natural resources. Today, Burma is one of the most tightly controlled dictatorships in the world, lacking any freedom of speech, assembly, or the press; denying any due process of law; and perpetuating human rights abuses, such as forced labor, military rape of civilians, political imprisonment, torture, trafficking in persons, and use of child soldiers. Burma is also facing what the United Nations Children's Fund (UNICEF) has called a "silent emergency," a health crisis of epidemic proportions. HIV/AIDS is spreading rapidly, and malaria, tuberculosis, leprosy, maternal mortality, and malnutrition are pervasive. Government spending on health and education is miniscule.

Burma is a leading producer of opium and methamphetamine for the illegal drug trade, which is a major source of corruption within Burma. Four decades of military operations against insurgent ethnic nationalities as well as mass forced relocations have created one of the largest refugee populations in Asia. As many as two million people have fled Burma for political and economic reasons; inside Burma, hundreds of thousands have been internally displaced. They lack access to food, health care, schools, and even clean water.

In August 1988, a popular uprising against the military regime was brutally suppressed and thousands were killed. In 1990, the regime held elections for a multi-party parliament in which the National League for

Democracy (NLD), led by Aung San Suu Kyi who was then under house arrest, won 82 percent of the seats. However, the elections were ignored by the junta and the elected parliamentary representatives never took office. The regime imprisoned hundreds of pro-democracy supporters, including elected members of parliament. Thousands more fled the country.

After the 1988 uprising, the United States imposed graduated sanctions on Burma, initially terminating economic aid, withdrawing trade preferences, imposing an arms embargo, and blocking loans the grants from international financial institutions. In 1997, based on a presidential finding that the Burmese government had committed large-scale repression and violence against the democratic opposition, the United States banned any new American investments in Burma.

In 2000, the United Nations, mandated by UN General Assembly resolutions, sent Special Envoy Razali Ismail to Rangoon to promote substantive political dialogue on transition to democratic government between Burmese government and the democratic opposition. Since then, Ambassador Razali has visited Rangoon nine times with no apparent progress toward establishing this dialogue. He is returning to Rangoon in early June.

In order to strengthen international efforts to install democratic government and end repression in Burma, the Task Force recommends that the United States take specific initiatives in four key areas:

Humanitarian assistance to address Burma's health crisis

In view of Burma's massive public health crisis, the United States should increase humanitarian assistance to Burma, provided that funds are given to international nongovernmental organizations (NGOs) for basic human needs through a process that requires transparency, accountability, and consultation with the NLD and other groups representatives of a multiethnic Burma.

Although the United States should not generally provide humanitarian assistance directly to the Burmese government, the United States could provide technical assistance to the Ministry of Health if the Burmese government agrees to meet the U.S. Centers for Disease Control (CDC) standard that HIV/AIDS testing be voluntary and confidential.

The United States should work together with other donor governments, UN agencies, and if possible, the Burmese government State Peace and Development Council (SPDC) to establish certain minimal standards of independence for international NGOs operating in Burma, including clear guidelines for administrative operations, reporting, and other regulations involving duty-free entry privileges, memoranda of understanding and residency permits.

Promoting democracy, human rights, and the rule of law

In view of the recent government-sponsored attacks on members of the democratic opposition, resulting in a number of deaths, and the Burmese government's detention of Aung San Suu Kyi, the United States should urge the United Nations Security Council to adopt a resolution that demands the immediate release of Aung San Suu Kyi and all political prisoners and condemns the Burmese government's egregious human rights abuses as well as its refusal to engage in substantive political dialogue with the democratic opposition. In addition, the United States should urge the Security Council to hold an emergency session on Burma to discuss imposing targeted sanctions, which could include denying visas to leaders of the military regime, the Union Solidarity Development Association (USDA) and their families, freezing their assets and imposing bans