

amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1018. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1019. Mr. CONRAD (for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 1020. Mr. CONRAD proposed an amendment to the bill S. 1, supra.

SA 1021. Mr. CONRAD proposed an amendment to the bill S. 1, supra.

SA 1022. Mr. BROWBACK submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1023. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1024. Mr. ENSIGN (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1025. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1026. Mr. HAGEL (for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1027. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1028. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1029. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1030. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1031. Mr. CARPER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1032. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1033. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1034. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1035. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1036. Mr. REID (for Mrs. BOXER) proposed an amendment to the bill S. 1, supra.

SA 1037. Mr. REID (for Mr. CORZINE) proposed an amendment to the bill S. 1, supra.

SA 1038. Mr. REID (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, supra.

SA 1039. Mr. REID (for Mr. INOUE) proposed an amendment to the bill S. 1, supra.

SA 1040. Mr. SCHUMER (for himself, Mr. CORZINE, Mrs. CLINTON, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1041. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1042. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1043. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 1001. Mrs. BOXER (for herself and Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 49, strike line 3 through page 50, line 2 and insert the following:

“(2) LIMITS ON COST-SHARING.—

“(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket limit under paragraph (4)) 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.

“(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a).

SA 1002. Mrs. LINCOLN (for herself, Mr. CONRAD, Mr. MILLER, Mr. CARPER, Mr. JOHNSON, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DORGAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 83, strike lines 1 through 7, and insert the following:

“(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

“(A) The contract shall be for a 2-year period.

“(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

“(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. ____ MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking “promptly (as determined in accordance with regulations)”;

(B) in subparagraph (B)—

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

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

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

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.”; and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received”; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.”

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

SA 1003. Mr. BROWNBACk (for himself and Mr. NELSON of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:
SEC. RURAL COMMUNITY HOSPITAL ASSISTANCE.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end of the following new subsection: “Rural Community Hospital; Rural Community Hospital Services “(ww)(1) The term ‘rural community hospital’ means a hospital (as defined in subsection (e)) that—

“(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

“(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report; 10

“(C) makes available 24-hour emergency care services;

“(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2003; and

“(E) applies to the Secretary for such designation.

“(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

“(3) Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

“(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) with the same service area (as defined by the Secretary in regulations in effect on such date).

“(B) A facility obtaining a new provider number pursuant to a change of ownership.

“(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2003.

“(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.”.

(2) PAYMENT.—

(A) INPATIENT SERVICES.—Section 1814 (42 U.S.C. 1395f) is amended by adding at the end of the following new subsection: “Payment for Inpatient Services Furnished in Rural Community Hospitals

“(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(ww)(1)(E)—

“(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

“(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).”.

(B) OUTPATIENT SERVICES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end of the following new subsection:

“(n) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(ww)(1)(E)—

“(1) the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

“(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).”.

(C) HOME HEALTH SERVICES.—

(i) EXCLUSION FROM HOME HEALTH PPS.—Section 1895 (42 U.S.C. 1395fff) is amended by adding at the end of the following:

“(f) EXCLUSION.—

“(1) IN GENERAL.—In determining payments under this title for home health services furnished on or after October 1, 2003, by a qualified RCH-based home health agency (as defined in paragraph (2))—

“(A) the agency may make a one-time election to waive application of the prospective payment system established under this section to such services furnished by the agency shall not apply; and

“(B) in the case of such an election, payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under paragraph (1)(L) of such section.

“(2) QUALIFIED RCH-BASED HOME HEALTH AGENCY DEFINED.—For purposes of paragraph (1), a ‘qualified RCH-based home health agency’ is a home health agency that is a provider-based entity (as defined in section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554; Appendix F, 114 Stat. 2763A-506)) of a rural community hospital that is located—

“(A) in a county in which no main or branch office of another home health agency is located; or

“(B) at least 35 miles from any main or branch office of another home health agency.”.

(ii) CONFORMING CHANGES.—

(I) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting “or with respect to services to which section 1895(f) applies” after “equipment” in the matter preceding paragraph (1).

(II) PAYMENTS UNDER PART B.—Section 1833(a)(2)(A) (42 U.S.C. 13951(a)(2)(A)) is amended by striking “the prospective payment system under”.

(III) PER VISIT LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended by inserting “(other than by a qualified RCH-based home health agency (as defined in section 1895(f)(2))” after “with respect to services furnished by home health agencies”.

(iii) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended by inserting “and excluding home health services to which section 1895(f) applies” after “provided for in such section”.

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended by inserting before the period at the end of the second sentence the following: “and paragraph (21) shall not apply to home health services to which section 1895(f) applies”.

(D) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)) is amended—

(i) by inserting “(i)” after “(P)”;

(ii) by adding at the end of the following:

“(ii)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(g)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a rural community hospital on or after October 1, 2003, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i).

“(1) The services referred to in subclause (I) are inpatient hospital services, outpatient hospital services, home health services furnished by an RCH-based home health agency (as defined in section 1895(f)(2)), and ambulance services.

“(II) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.”.

(E) EXEMPTION FROM 30 PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting “(other than a rural community hospital)” after “In determining such reasonable costs for hospitals”.

(3) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(n) (as added by paragraph (2)(B)) is amended—

(A) by inserting “(1)” after “(n)”; and

(B) by adding at the end of the following:

“(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

“(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

“(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost-sharing shall apply.

“(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.”.

(4) CONFORMING AMENDMENTS.—

(A) PART A PAYMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended by inserting “other than inpatient hospital services furnished by a rural community hospital,” after “critical access hospital services.”.

(B) PART B PAYMENT.—

(i) IN GENERAL.—Section 1833(a) (42 U.S.C. 13951(a)) is amended—

(I) in paragraph (2), in the matter before subparagraph (A), by striking “and (I)” and inserting “(I), and (K)”;

(II) by striking “and” at the end of paragraph (8);

(III) by striking the period at the end of paragraph (9) and inserting “; and”; and

(IV) by adding at the end of the following: “(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(n).”.

(ii) AMBULANCE SERVICES.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205 (a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A-463), as enacted into law by section 1(a)(6) of Public Law 106-554, is amended—

(I) in the heading, by striking “CRITICAL ACCESS HOSPITALS” and inserting “CERTAIN FACILITIES”;

(II) by striking “or” at the end of subparagraph (A);

(III) by redesignating subparagraph (B) as subparagraph (C);

(IV) by inserting after subparagraph (A) the following new subparagraph:

“(B) by a rural community hospital (as defined in section 1861(ww)(1)), or”; and (V) in subparagraph (C), as so redesignated, by inserting “or a rural community hospital” after “critical access hospital”.

(C) TECHNICAL AMENDMENTS.—

(1) CONSULTATION WITH STATE AGENCIES.—Section 1863 (42 U.S.C. 1395z) is amended by striking “and (dd)(2)” and inserting “(dd)(2), (mm)(1), and (ww)(1)”.

(ii) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting “section 1834(n)(2),” after “section 1833(b).”

(iii) BIPA AMENDMENT.—Paragraph (8) of section 1834(1) (42 U.S.C. 1395m(1)), as added by section 221 (a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–486), as enacted into law by section 1(a)(6) of Public Law 106–554, is redesignated as paragraph (9).

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after October 1, 2003.

(b) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY RCH AND CAH FACILITIES.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by striking “a distinct part of the hospital (as defined by the Secretary)” in the matter following clause (v) and inserting “a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital or a rural community hospital”.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to determinations with respect to distinct part unit status that are made on or after October 1, 2003.

(c) IMPROVEMENTS TO MEDICARE CRITICAL ACCESS HOSPITAL (CAH) PROGRAM.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

“(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 10.”

(2) PAYMENTS TO HOME HEALTH AGENCIES OWNED AND OPERATED BY A CAH.—Section 1895(f) (42 U.S.C. 1395fff(f)), as added by subsection (a)(2)(C), is further amended by inserting “or by a home health agency that is owned and operated by a critical access hospital (as defined in section 1861(mm)(1))” after “as defined in paragraph (2))”.

(3) PAYMENTS TO CAH-OWNED SNFS.—(A) IN GENERAL.—Section 1888(e)(42 U.S.C. 1395vy(e)) is amended—

(i) in paragraph (1), by striking “and (12)” and inserting “(12), and (13)”; and

(ii) by adding at the end thereof the following:

“(13) EXEMPTION OF CAH FACILITIES FROM PPS.—In determining payments under this part for covered skilled nursing facility services furnished on or after October 1, 2003, by a skilled nursing facility that is a distinct part unit of a critical access hospital (as defined in section 1861(mm)(1)) or is owned and operated by a critical access hospital—

“(A) the prospective payment system established under this subsection shall not apply; and

“(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services or the limitations established under subsection (a).”

(B) CONFORMING CHANGES.—

(i) IN GENERAL.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by subsection (a), is further amended in the matter preceding paragraph (1)—

(I) by inserting “other than a skilled nursing facility providing covered skilled nursing facility services (as defined in section 1888(e)(2)) or post hospital extended care services to which section 1888(e)(13) applies,” after “inpatient critical access hospital services”; and

(II) by striking “1813 1886,” and inserting “1813, 1886, 1888.”

(i) CONSOLIDATED BILLING.—

(I) RECIPIENT OF PAYMENT.—Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by inserting “services to which paragraph (7)(C) or (13) of section 1888(e) applies and” after “other than”.

(II) EXCEPTION TO EXCLUSION FROM COVERAGE.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended by inserting “(other than services to which paragraph (7)(C) or (13) of section 1888(e) applies)” after “section 1888(e)(2)(A)(i)”.

(4) PAYMENTS TO DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS OF CAHS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(A) in paragraph (1), by inserting “, other than a distinct part psychiatric or rehabilitation unit to which paragraph (8) applies,” after “subsection (d)(1)(B)”; and

(B) by adding at the end the following:

“(8) EXEMPTION OF CERTAIN DISTINCT PART PSYCHIATRIC OR REHABILITATION UNITS FROM COST LIMITS.—In determining payments under this part for inpatient hospital services furnished on or after October 1, 2003, by a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of subsection (d)(1)(B)) of a critical access hospital (as defined in section 1861(mm)(1))—

“(A) the limits imposed under the preceding paragraphs of this subsection shall not apply; and

“(B) payment shall be made on the basis of the reasonable costs incurred in furnishing such services as determined under section 1861(v), but without regard to the amount of the customary or other charges with respect to such services.”

(5) RETURN ON EQUITY.—Section 1861(v)(1)(P) (42 U.S.C. 1395x(v)(1)(P)), as amended by subsection (a)(2)(D), is further amended by adding at the end the following:

“(11)(I) Notwithstanding clause (i), subparagraph (S)(i), and section 1886(8)(2), such regulations shall provide, in determining the reasonable costs of the services described in subclause (II) furnished by a critical access hospital on or after October 1, 2003, for payment of a return on equity capital at a rate of return equal to 150 percent of the average specified in clause (i).

“(II) The services referred to in subclause (I) are inpatient critical access hospital services (as defined in section 1861(mm)(2)), outpatient critical access hospital services (as defined in section 1861(mm)(3)), extended care services provided pursuant to an agreement under section 1883, posthospital extended care services to which section 1888(e)(13) applies, home health services to which section 1895(f) applies, ambulance services to which section 1834(l) applies, and inpatient hospital services to which section 1886(b)(8) applies.

“(III) Payment under this clause shall be made without regard to whether a provider is a proprietary provider.”

(6) TECHNICAL CORRECTIONS.—

(A) SECTION 403(b) OF BBA 1999.—Section 1820(b)(2) (42 U.S.C. 1395i–4(b)(2)) is amended by striking “nonprofit or public hospitals” and inserting “hospitals”.

(B) SECTION 203(b) OF BIPA 2000.—Section 1883(a)(3) (42 U.S.C. 1395tt(a)(3)) is amended—

(i) by inserting “section 1861(v)(1)(G) or” after “Notwithstanding”; and

(ii) by striking “covered skilled nursing facility”.

(9) EFFECTIVE DATES.—

(A) ELIMINATION OF REQUIREMENTS.—The amendments made by paragraphs (1) and (2) shall apply to services furnished on or after October 1, 2003.

(B) TECHNICAL CORRECTIONS.—

(i) BBA.—The amendment made by paragraph (6)(A) shall be effective as if included in the enactment of section 403(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–321), as enacted into law by section 1000(a)(6) of Public Law 106–113.

(ii) BIPA.—The amendments made by paragraph (6)(B) shall be effective as if included in the enactment of section 203(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SA 1004. Mrs. HUTCHISON proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. . . . FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

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

(2) by striking subclause (VII) and inserting the following new subclauses:

“(VII) during fiscal years 2003, 2004, 2005, 2006, 2007 and 2008, ‘c’ is equal to 1.35; and

“(VIII) on or after October 1, 2008, ‘c’ is equal to 1.6.”

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—

Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking “1999 or” and inserting “1999.”; and

(2) by inserting “, or the Prescription Drug and Medicare Improvement Act of 2003” after “2000”.

SA 1005. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. . . . EXTENSION OF PHASE-IN OF NEW RISK ADJUSTER.

(a) UNDER MEDICARE+CHOICE.—Section 1853(a)(3)(C)(ii) is amended—

(1) in subclause (I), by striking “2003” and inserting “2005”; and

(2) in subclause (II), by striking “2004” and inserting “2006”; and

(3) in subclause (III), by striking “2005” and inserting “2007”; and

(4) in subclause (IV), by striking “2006” and inserting “2008”; and

(5) in subclause (V), by striking “2007” and inserting “2009”.

(b) UNDER MEDICAREADVANTAGE.—Section 1853(a)(3)(A) (42 U.S.C. 1395w-23(a)(3)(A)), as amended by section 203, is amended to read as follows:

“(A) APPLICATION OF METHODOLOGY.—

“(i) IN GENERAL.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to the applicable percentage of the amount of payments to plans under subsection (d)(4)(B).

“(ii) APPLICABLE PERCENTAGE DEFINED.—For purposes of clause (i), the term ‘applicable percentage’ means—

“(I) for 2006, 30 percent;

“(III) for 2007, 50 percent;

“(IV) for 2008, 75; and

“(V) for 2009 and each subsequent year, 100 percent.”.

(c) EFFECTIVE DATES.—The amendments made—

(1) by subsection (a) shall take effect on the date of enactment of this Act; and

(2) by subsection (b) shall apply to plan years beginning on or after January 1, 2006.

SA 1006. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. . . . REVISION OF REQUIREMENTS FOR REVIEW OF MARKETING MATERIALS.

(a) UNDER MEDICARE+CHOICE AND MEDICAREADVANTAGE.—Section 1851(h) (42 U.S.C. 1395w-21(h)) is amended—

(1) in paragraph (1)(A), by striking “45 days (or 10 days in the case described in paragraph (5))” and inserting “30 days (or 10 days in the case described in paragraph (5) or if the Medicare+Choice organization has submitted to the Secretary requested corrections following review of the submitted material)”; and

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

“(2) REVIEW.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), 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.

“(B) EXCEPTION.—Notwithstanding any other requirements of section 1856(h), the Secretary shall establish policies that permit, under appropriate circumstances, the distribution of marketing materials by a Medicare+Choice organization prior to review.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to section 1851(h) of the Social Security Act (42 U.S.C. 1395w-21(h)) as in effect on such date and as amended by section 201.

SA 1007. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle C of title II, add the following:

SEC. . . . AUTHORIZATION OF DIRECT PAYMENTS TO PROVIDERS FOR SERVICES PROVIDED TO MEDICARE ADVANTAGE ENROLLEES PARTICIPATING IN MEDICARE COVERED CLINICAL TRIALS.

(a) UNDER MEDICARE+CHOICE AND MEDICAREADVANTAGE.—

(1) IN GENERAL.—Section 1852(a)(1)(A) (42 U.S.C. 1395w-22(a)(1)(A)) is amended by inserting “and items and services that are covered under part A or B as a result of a national coverage determination for qualifying clinical trials” after “hospice care”.

(2) PAYMENT.—Section 1853 (42 U.S.C. 1395w-23) is amended by adding at the end the following new subsection:

“(j) SPECIAL RULE FOR COVERED COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS.—

“(1) INFORMATION.—The Medicare+Choice organization shall inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization that the medicare program covers certain costs associated with the participation by a medicare beneficiary in a qualifying clinical trial.

“(2) PAYMENT.—If an individual who is enrolled with a Medicare+Choice organization under this part participates in a qualifying clinical trial, payment for the medicare covered costs associated with that clinical trial shall be made by the Secretary directly to the provider or supplier furnishing such services.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act and shall apply to sections 1852 and 1853 of the Social Security Act (42 U.S.C. 1395w-22 and 1395w-23) as in effect on such date and as amended by sections 202 and 203.

SA 1008. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 134, between lines 9 and 10, insert the following:

“(d) ZERO PREMIUM STOP-LOSS PROTECTION AND ACCESS TO NEGOTIATED PRICES FOR CERTAIN ELIGIBLE BENEFICIARIES ENROLLED IN THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM AFTER 2013.—

“(1) IN GENERAL.—Notwithstanding the preceding provisions of this part, the following rules shall apply with respect to an applicable eligible beneficiary enrolled in a Medicare Prescription Drug plan or under a contract under section 1860D-13(e):

“(A) NO PREMIUM.—Notwithstanding sections 1860D-13(e)(2) and 1860D-17, the monthly beneficiary obligation for enrollment in the Medicare Prescription Drug plan or under a contract under section 1860D-13(e) shall be zero.

“(B) BENEFICIARY RECEIVES ACCESS TO NEGOTIATED PRICES AND STOP-LOSS PROTECTION FOR NO ADDITIONAL PREMIUM.—Notwithstanding section 1860D-6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

“(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

“(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4).

“(iii) The coverage provides access to negotiated prices under subsection (e) of such section during the entire year.

“(C) APPLICATION OF LOW-INCOME SUBSIDIES.—Notwithstanding section 1860D-19, the Administrator shall not apply the following provisions of subsection (a) of such section:

“(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

“(ii) Subparagraphs (A), (B), (C), and (D) of paragraph (2).

“(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

“(2) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term ‘applicable eligible beneficiary’ means an eligible beneficiary who—

“(A) is enrolled under this part; and

“(B) became an eligible beneficiary for the first time on or after January 1, 2014.

“(3) PROCEDURES.—The Administrator shall establish procedures to carry out this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part to the extent necessary to carry out this subsection.

“(4) NO EFFECT ON BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN THAT PROVIDES QUALIFIED PRESCRIPTION DRUG COVERAGE.—This subsection shall have no effect on eligible beneficiaries enrolled in this part and under a MedicareAdvantage plan that provides qualified prescription drug coverage.”.

SA 1009. Mr. INOUYE (for himself and Mr. AKAKA) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. . . . 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting “, and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider” before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SA 1010. Mr. SUNUNU submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . . . IMPROVEMENT OF OUTPATIENT VISION SERVICES UNDER PART B.

(a) COVERAGE UNDER PART B.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking “and” after the semicolon at the end;

(2) in subparagraph (V)(iii), by adding “and” after the semicolon at the end; and

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

“(W) vision rehabilitation services (as defined in subsection (ww)(1));”.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Vision Rehabilitation Services; Vision Rehabilitation Professional

“(ww)(1)(A) The term ‘vision rehabilitation services’ means rehabilitative services (as determined by the Secretary in regulations) furnished—

“(i) to an individual diagnosed with a vision impairment (as defined in paragraph (6));

“(ii) pursuant to a plan of care established by a qualified physician (as defined in subparagraph (C)) or by a qualified occupational therapist that is periodically reviewed by a qualified physician;

“(iii) in an appropriate setting (including the home of the individual receiving such services if specified in the plan of care); and

“(iv) by any of the following individuals:

“(I) A qualified physician.

“(II) A qualified occupational therapist.

“(III) A vision rehabilitation professional (as defined in paragraph (2)) while under the general supervision (as defined in subparagraph (D)) of a qualified physician.

“(B) In the case of vision rehabilitation services furnished by a vision rehabilitation professional, the plan of care may only be established and reviewed by a qualified physician.

“(C) The term ‘qualified physician’ means—

“(i) a physician (as defined in subsection (r)(1)) who is an ophthalmologist; or

“(ii) a physician (as defined in subsection (r)(4) (relating to a doctor of optometry)).

“(D) The term ‘general supervision’ means, with respect to a vision rehabilitation professional, overall direction and control of that professional by the qualified physician who established the plan of care for the individual, but the presence of the qualified physician is not required during the furnishing of vision rehabilitation services by that professional to the individual.

“(2) The term ‘vision rehabilitation professional’ means any of the following individuals:

“(A) An orientation and mobility specialist (as defined in paragraph (3)).

“(B) A rehabilitation teacher (as defined in paragraph (4)).

“(C) A low vision therapist (as defined in paragraph (5)).

“(3) The term ‘orientation and mobility specialist’ means an individual who—

“(A) if a State requires licensure or certification of orientation and mobility specialists, is licensed or certified by that State as an orientation and mobility specialist;

“(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in orientation and mobility; and

“(ii) has successfully completed 350 hours of clinical practicum under the supervision of an orientation and mobility specialist and has furnished not less than 9 months of supervised full-time orientation and mobility services;

“(C) has successfully completed the national examination in orientation and mobility administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

“(D) meets such other criteria as the Secretary establishes.

“(4) The term ‘rehabilitation teacher’ means an individual who—

“(A) if a State requires licensure or certification of rehabilitation teachers, is licensed or certified by the State as a rehabilitation teacher;

“(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in rehabilitation teaching, or holds such a degree in a health field; and

“(ii) has successfully completed 350 hours of clinical practicum under the supervision of a rehabilitation teacher and has furnished not less than 9 months of supervised full-time rehabilitation teaching services;

“(C) has successfully completed the national examination in rehabilitation teaching administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

“(D) meets such other criteria as the Secretary establishes.

“(5) The term ‘low vision therapist’ means an individual who—

“(A) if a State requires licensure or certification of low vision therapists, is licensed or certified by the State as a low vision therapist;

“(B)(i) holds a baccalaureate or higher degree from an accredited college or university in the United States (or an equivalent foreign degree) with a concentration in low vision therapy, or holds such a degree in a health field; and

“(ii) has successfully completed 350 hours of clinical practicum under the supervision of a physician, and has furnished not less than 9 months of supervised full-time low vision therapy services;

“(C) has successfully completed the national examination in low vision therapy administered by the Academy for Certification of Vision Rehabilitation and Education Professionals; and

“(D) meets such other criteria as the Secretary establishes.

“(6) The term ‘vision impairment’ means vision loss that constitutes a significant limitation of visual capability resulting from disease, trauma, or a congenital or degenerative condition that cannot be corrected by conventional means, including refractive correction, medication, or surgery, and that is manifested by 1 or more of the following:

“(A) Best corrected visual acuity of less than 20/60, or significant central field defect.

“(B) Significant peripheral field defect including homonymous or heteronymous bilateral visual field defect or generalized contraction or constriction of field.

“(C) Reduced peak contrast sensitivity in conjunction with a condition described in subparagraph (A) or (B).

“(D) Such other diagnoses, indications, or other manifestations as the Secretary may determine to be appropriate.”.

(c) PAYMENT UNDER PART B.—

(1) PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting “(2)(W),” after “(2)(S).”.

(2) CARVE OUT FROM HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting “vision rehabilitation services (as defined in section 1861(ww)(1)) or” after “does not include”.

(3) CLARIFICATION OF BILLING REQUIREMENTS.—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking “and” before “(G)”;

(B) by inserting before the period the following: “, and (H) in the case of vision rehabilitation services (as defined in section 1861(ww)(1)) furnished by a vision rehabilita-

tion professional (as defined in section 1861(ww)(2)) while under the general supervision (as defined in section 1861(ww)(1)(D)) of a qualified physician (as defined in section 1861(ww)(1)(C)), payment shall be made to (i) the qualified physician or (ii) the facility (such as a rehabilitation agency, a clinic, or other facility) through which such services are furnished under the plan of care if there is a contractual arrangement between the vision rehabilitation professional and the facility under which the facility submits the bill for such services”.

(d) PLAN OF CARE.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) in subparagraph (E), by striking “and” after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting “; and”; and

(3) by inserting after subparagraph (F) the following new subparagraph:

“(G) in the case of vision rehabilitation services, (i) such services are or were required because the individual needed vision rehabilitation services, (ii) an individualized, written plan for furnishing such services has been established (I) by a qualified physician (as defined in section 1861(ww)(1)(C)), (II) by a qualified occupational therapist, or (III) in the case of such services furnished by a vision rehabilitation professional, by a qualified physician, (iii) the plan is periodically reviewed by the qualified physician, and (iv) such services are or were furnished while the individual is or was under the care of the qualified physician.”.

(e) RELATIONSHIP TO REHABILITATION ACT OF 1973.—The provision of vision rehabilitation services under the medicare program under title XVIII (42 U.S.C. 1395 et seq.) shall not be taken into account for any purpose under the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.).

(f) EFFECTIVE DATE.—

(1) INTERIM, FINAL REGULATIONS.—The Secretary shall publish a rule under this section in the Federal Register by not later than 180 days after the date of enactment of this Act to carry out the provisions of this section. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period for public comment of not less than 60 days.

(2) CONSULTATION.—The Secretary shall consult with the National Vision Rehabilitation Cooperative, the Association for Education and Rehabilitation of the Blind and Visually Impaired, the Academy for Certification of Vision Rehabilitation and Education Professionals, the American Academy of Ophthalmology, the American Occupational Therapy Association, the American Optometric Association, and such other qualified professional and consumer organizations as the Secretary determines appropriate in promulgating regulations to carry out this section.

SA 1011. Mr. SESSIONS proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Strike section 605 and insert the following:
SEC. 605. SENSE OF THE SENATE REGARDING HEALTH INSURANCE COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND SCHIP.

FINDINGS.—The Senate makes the following findings:

(1) In 1996, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193; 110 Stat. 2105) commonly referred to as the “welfare

reform Act'), Congress deliberately limited the Federal public benefits available to legal immigrants.

(2) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows a State the option of electing to offer permanent resident legal aliens that have been living in the United States for at least 5 years the same benefits that their State citizens receive under the temporary assistance for needy families program (commonly referred to as "TANF") and the medicaid program.

(3) As of the date of enactment of this Act, 22 States have elected to give the permanent resident legal aliens who reside in their States the same TANF and medicaid benefits as the States provide to the citizens of their States.

(4) This Act, the Prescription Drug and Medicare Improvement Act of 2003, is not a welfare or medicaid reform bill, but rather is a package of improvements for the medicare program that is designed to provide greater access to health care for America's seniors.

(5) The section heading for 605 of this Act as reported out of the Committee on Finance, was titled "Assistance with Coverage of Legal Immigrants under the medicaid program and SCHIP," and, as reported, related directly to the provision of benefits under the medicaid and State children's health insurance programs, not to benefits provided under the medicare program.

(6) The reported version of section 605 would have directly overturned the reforms made in the 1996 welfare reform Act.

(7) The reported version of section 605 would have greatly expanded the number of individuals who could receive benefits under medicaid and SCHIP.

(8) No hearings have been held in the Committee on Finance of the Senate concerning why the 5-year residency requirement for legal aliens to obtain a Federal public benefit established in the welfare reform Act needs to be overturned or why the reported version of section 605 should be included in a medicare reform package.

(9) Congress must reauthorize the temporary assistance for needy families program later this year and should hold hearings regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit should be overturned as part of the reauthorization of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Committee on Finance of the Senate should hold hearings in connection with the reauthorization of the temporary assistance for needy families program, or in connection with reform of the medicaid program, regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit that was established in the 1996 welfare reform Act should be overturned for purposes of the medicaid and State children's health insurance programs.

SA 1012. Mr. HAGEL (for himself and Mr. ENSIGN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Title I is amended by adding at the end the following:

Subtitle E—Voluntary Medicare Prescription Drug Discount and Security Program

SEC. 141. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 101, is amended—

- (1) by redesignating part E as part F; and
- (2) by inserting after part D the following new part:

"PART E—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

"DEFINITIONS

"SEC. 1860E. In this part:

"(1) COVERED DRUG.—

"(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

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

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or 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.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered 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 appealed under section 1860E-4(a)(4)(B).

"(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or 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 E; 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 1860E-4(a)(4).

"(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

"(A) eligible for benefits under part A or enrolled under part B; and

"(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

"(A) pharmaceutical benefit management company;

"(B) wholesale pharmacy delivery system;

"(C) retail pharmacy delivery system;

"(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

"(E) MedicareAdvantage organization;

"(F) State (in conjunction with a pharmaceutical benefit management company);

"(G) employer-sponsored plan;

"(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

"(I) combination of the entities described in subparagraphs (A) through (H).

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

"(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

"ESTABLISHMENT OF PROGRAM

"SEC. 1860E-1. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part. Notwithstanding any other provision of this title, an eligible beneficiary may elect to enroll in the program under this part in lieu of the program established under part D. An eligible beneficiary may not be enrolled under both this part and part D.

"(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

"(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

"(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

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

"(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"ENROLLMENT

"SEC. 1860E-2. (a) ENROLLMENT UNDER PART E.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

"(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

"(2) ENROLLMENT PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

"(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in

which such beneficiaries may enroll under this part.

“(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

“(i) enroll under this part; or

“(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

“(3) PERIOD OF COVERAGE.—

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

“(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) 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.

“(4) PART E COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

“(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual’s coverage under this part if the individual is—

“(i) no longer enrolled in part A or B; or

“(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

“(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

“(i) the termination of coverage under part A or (if later) under part B; or

“(ii) the coverage under title XIX.

“(B) ENROLLMENT WITH ELIGIBLE ENTITY.—

“(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

“(2) ELECTION PERIODS.—

“(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the MedicareAdvantage program under section 1851(e), including—

“(i) annual coordinated election periods; and

“(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a MedicareAdvantage election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

“(B) INITIAL ELECTION PERIODS.—

“(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

“(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled

to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

“(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

“(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

“(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

“(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

“(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

“(3) MEDICAREADVANTAGE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the MedicareAdvantage organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

“(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

“(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICAREADVANTAGE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a MedicareAdvantage plan.

“(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a MedicareAdvantage 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) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under sec-

tion 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)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(F) VETERANS’ COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

“(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

“PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

“SEC. 1860E-3. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

“(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860E-2(c).

“ENROLLEE PROTECTIONS

“SEC. 1860E-4. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

“(1) GUARANTEED ISSUANCE AND NON-DISCRIMINATION.—

“(A) GUARANTEED ISSUANCE.—

“(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860E-2(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

“(ii) MEDICAREADVANTAGE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

“(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

“(2) DISCLOSURE OF INFORMATION.—

“(A) INFORMATION.—

“(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

“(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

“(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

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

“(III) Information on grievance and appeals procedures.

“(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

“(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

“(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

“(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

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

“(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

“(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

“(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card 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.

“(4) APPEALS.—

“(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescrip-

tion drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

“(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity 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.

“(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

“(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

“(1) ACCESS TO COVERED BENEFITS.—

“(A) ASSURING PHARMACY ACCESS.—

“(i) IN GENERAL.—The eligible entity offering the prescription drug discount card 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 Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860E-4(a)(3) that ensure such convenient access.

“(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card 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) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860E-6(b).

“(B) USE OF STANDARDIZED TECHNOLOGY.—

“(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860E-6(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

“(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

“(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

“(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of in-

dividuals who are a physician or a practicing pharmacist (or both).

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

“(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

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

“(v) 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 physicians.

“(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860E-4(a).

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

“(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

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

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

“(iii) 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.

“(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

“(i) 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 ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

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

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

“(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.

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

“(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

“(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug discount card plans under this part with respect to the following requirements, in the same manner as they apply to Medicare Advantage plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

“(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

“(ii) Subsection (c)(1) (relating to access to covered benefits).

“(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

“(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card 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 drug covered under the plan that is therapeutically equivalent and bioequivalent.

“ANNUAL ENROLLMENT FEE

“SEC. 1860E-5. (a) AMOUNT.—

“(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of \$25.

“(2) ANNUAL PERCENTAGE INCREASE.—

“(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment.

“(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

“(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

“(ii) such aggregate expenditures for the 12-month period ending with July 2005.

“(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of \$1, such increase shall be rounded to the nearest multiple of \$1.

“(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

“(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

“(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

“(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

“BENEFITS UNDER THE PROGRAM

“SEC. 1860E-6. (a) ACCESS TO NEGOTIATED PRICES.—

“(1) NEGOTIATED PRICES.—

“(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860E-8(b). For purposes of this subparagraph, the term ‘prescription drugs’ is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

“(B) LIMITATIONS.—

“(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

“(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

“(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

“(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

“(b) CATASTROPHIC BENEFIT.—

“(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

“(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

“(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860E-9) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to \$1,500.

“(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to \$3,500.

“(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY

LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to \$5,500.

“(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary’s income for that year (rounded to the nearest multiple of \$1).

“(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

“(4) ANNUAL PERCENTAGE INCREASE.—

“(A) IN GENERAL.—In the case of any calendar year after 2005, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment determined under section 1860E-5(a)(2)(B) for such calendar year.

“(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of \$1, such increase shall be rounded to the nearest multiple of \$1.

“(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

“(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

“(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860E-8.

“(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

“REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

“SEC. 1860E-7. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

“(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

“(c) ADMINISTRATIVE FEE BID.—

“(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

“(2) BID SUBMISSION REQUIREMENTS.—

“(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

“(i) Enrollment, including income eligibility determination.

“(ii) Claims processing.

“(iii) Quality assurance, including drug utilization review.

“(iv) Beneficiary and pharmacy customer service.

“(v) Coordination of benefits.

“(vi) Fraud and abuse prevention.

“(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

“(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

“(i) Additional fees charged to the beneficiary, not to exceed \$25 annually.

“(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

“(d) AWARDING OF CONTRACTS.—

“(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

“(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

“(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

“(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

“(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

“(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

“(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

“(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

“(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

“(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

“(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health 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.

“(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section 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).

“(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

“(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

“(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

“PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

“SEC. 1860E-8. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

“(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860E-6(b); and

“(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860E-7.

“(b) PAYMENT FOR COVERED DRUGS.—

“(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860E-6(b).

“(2) LIMITATIONS.—

“(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860E-4(a)(4)(B).

“(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860E-6(a) or the price negotiated for insurance coverage under the Medicare Advantage program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

“(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

“(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

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

“DETERMINATION OF INCOME LEVELS

“SEC. 1860E-9. (a) DETERMINATION OF INCOME LEVELS.—

“(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E-5(c) and 1860E-6(b).

“(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

“(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

“(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E-5(c) and 1860E-6(b); and

“(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

“(c) QUALITY CONTROL SYSTEM.—

“(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

“(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

“APPROPRIATIONS

“SEC. 1860E-10. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E-5.

"MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

"SEC. 1860E-11. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

"(b) ADVICE ON POLICIES; REPORTS.—

"(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

"(2) REPORTS.—

"(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary 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 the program under this part. Each such report shall be published in the Federal Register.

"(B) 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.

"(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

"(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

"(A) PRESIDENTIAL APPOINTMENTS.—

"(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

"(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

"(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) 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.

"(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

"(2) 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, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

"(3) COMPOSITION.—Of the members appointed under paragraph (1)—

"(A) at least 1 shall represent the pharmaceutical industry;

"(B) at least 1 shall represent physicians;

"(C) at least 1 shall represent medicare beneficiaries;

"(D) at least 1 shall represent practicing pharmacists; and

"(E) at least 1 shall represent eligible entities.

"(d) TERMS OF APPOINTMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

"(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

"(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

"(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

"(I) 2 years;

"(II) 4 years; and

"(III) 6 years.

"(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

"(I) 3 years; and

"(II) 6 years.

"(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

"(I) 4 years; and

"(II) 5 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

"(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

"(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

"(g) MEETINGS.—

"(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

"(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

"(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

"(i) PERSONNEL.—

"(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

"(2) STAFF.—

"(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

"(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

"(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section."

(b) CONFORMING REFERENCES TO PREVIOUS PART E.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part E of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

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

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part E of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860E of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part E of title XVIII of the Social Security Act (as added by section 101).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART E 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”;

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

“(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part E.”.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

“(1) PROMULGATION OF MODEL REGULATION.—

“(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the ‘NAIC’) changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as ‘J’ under the standards established by subsection (p)(2) (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) so that—

“(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

“(ii) a uniform format is used in the policy with respect to such revised benefits; and

“(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ‘2006 NAIC Model Regulation’).

“(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the ‘2006 Federal Regulation’).

“(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this para-

graph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

“(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part E of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

“(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as ‘A’ through ‘I’ under the standards established by subsection (p)(2) (including the benefit package classified as ‘F’ with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part E.

“(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

“(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

“(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

“(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

“(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.”.

SA 1013. Mr. BOND (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. . . COMMITTEE ON DRUG COMPOUNDING.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish an Committee on Drug Compounding (referred to in this section as the “Committee”) within the Food and Drug Administration on drug compounding to ensure that patients are receiving necessary, safe and accurate dosages of compounded drugs.

(b) MEMBERSHIP.—The membership of the Advisory Committee shall be appointed by the Secretary of Health and Human Services and shall include representatives of—

(1) the National Association of Boards of Pharmacy;

(2) pharmacy groups;

(3) physician groups;

(4) consumer and patient advocate groups;

(5) the United States Pharmacopoeia; and

(6) other individuals determined appropriate by the Secretary.

(c) REPORT AND RECOMMENDATIONS.—Not later than 1 year after the date of enactment of this Act, the Committee shall submit to the Secretary a report concerning the recommendations of the Committee to improve and protect patient safety.

(d) TERMINATION.—The Committee shall terminate on the date that is 1 year after the date of enactment of this Act.

SA 1014. Mr. BOND submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 483, line 7, strike “and” and insert “, pharmacy services, and”.

SA 1015. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. . . STUDY ON MAKING PRESCRIPTION PHARMACEUTICAL INFORMATION ACCESSIBLE FOR BLIND AND VISUALLY-IMPAIRED INDIVIDUALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall undertake a study of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually-impaired individuals.

(2) STUDY TO INCLUDE EXISTING AND EMERGING TECHNOLOGIES.—The study under paragraph (1) shall include a review of existing and emerging technologies, including assistive technology, that makes essential information on the content and prescribed use of pharmaceutical medicines available in a usable format for blind and visually-impaired individuals.

(b) REPORT.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study required under subsection (a).

(2) CONTENTS OF REPORT.—The report required under subsection (a) shall include recommendations for the implementation of usable formats for making prescription pharmaceutical information available to blind and visually-impaired individuals and an estimate of the costs associated with the implementation of each format.

SA 1016. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 654, after line 18 and before the amendment to the title, insert the following:

SEC. . . INFORMATION TECHNOLOGY.

(a) IMPROVING CLINICAL PRACTICES.—

(1) TELEMEDICINE.—

(A) LICENSING.—Section 1834(m)(4)(C)(i) (42 U.S.C. 1395m(m)(4)(C)(i)) is amended—

(i) in subclause (II), by striking “or” at the end;

(ii) in subclause (III), by striking the period and inserting “; or”;

(iii) by adding at the end the following:

“(IV) in a State in which the respective State medical board has adopted a formal

policy regarding licensing or certification requirements for providers at distant sites who do not have a license to practice medicine at the originating site.”.

(B) EXPANDING ELIGIBILITY FOR REIMBURSEMENT.—Section 1834(m)(4)(C)(i)(I) (42 U.S.C. 1395m(m)(4)(C)(i)(I)) is amended by striking “rural”.

(2) NIH TRIALS TO STUDY IMPACT OF TECHNOLOGY ON COST AND QUALITY OF HEALTH CARE.—

(A) FINDINGS.—Congress makes the following findings:

(i) An estimated 80,000 to 100,000 patients die every year from errors suffered during hospitalization.

(ii) Many of these errors could have been avoided with changes to the system of health care delivery.

(iii) These systemwide changes have the potential to decrease the cost of providing health care and to increase the quality of services provided.

(iv) These improvements in cost and quality can be as dramatic as improvements seen with new technology or pharmaceutical advances.

(v) Currently new medical devices and medications undergo rigorous randomized controlled clinical trials to document their effect on a patient’s health.

(vi) These clinical trials form the basis for providers to practice evidence-based medicine and to change their practices to improve their patients’ outcomes.

(vii) Similar controlled clinical studies of systems-based approaches to changing practice, if available, can help providers implement systems-based measures to improve outcomes.

(B) RESEARCH ON SYSTEMS-BASED APPROACHES TO CHANGING CLINICAL PRACTICE.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

“SEC. 409J. RESEARCH ON SYSTEMS-BASED APPROACHES TO CHANGING CLINICAL PRACTICE.

“(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Director of NIH a Medical Systems Safety Initiative (referred to in this section as the ‘Initiative’) to conduct and support research regarding systems-based approaches to improving and advancing medical care. The Initiative shall be headed by the Director of NIH (referred to in this section as the ‘Director’).

“(b) PURPOSE.—The purpose of the Initiative is to enable the Director of NIH—

“(1) to conduct and support basic and applied research (including both intramural and extramural research), research training, the dissemination of health information, and other programs with respect to systems research, user-centered design, and human factors engineering within the National Institutes of Health to realize the expanding opportunities for improving health outcomes through the analysis and redesign of medical systems;

“(2) to enhance collaborative efforts among the Institutes to conduct and support multidisciplinary research in the areas that the Director determines to be most promising; and

“(3) to encourage and support clinical studies to provide scientifically and statistically rigorous and meaningful information about the utility and effectiveness of various systems-based interventions.

“(c) APPROPRIATE SCIENTIFIC EXPERTISE AND COORDINATION WITH INSTITUTES AND FEDERAL AGENCIES.—The Director of NIH, after consultation with the Division of Research Grants, shall ensure that scientists with appropriate expertise in research on health systems, user-centered design, and human factors engineering are incorporated into the

review, oversight, and management processes of all research projects and other activities funded by the Initiative. In carrying out this subsection, the Director, as necessary, may establish review groups with appropriate scientific expertise. The Director shall coordinate efforts with other Institutes and Federal agencies to ensure appropriate scientific input and management.

“(d) ENSURING HIGH QUALITY, RIGOROUS SCIENTIFIC REVIEW.—In order to ensure high quality, rigorous scientific review with respect to the Initiative, the Director of NIH shall conduct or support the following activities:

(1) Outcomes research and investigations.

(2) Epidemiological studies on the incidence and prevalence of various systems, practices, and processes within the health care system and their effect on health outcomes, both beneficial and harmful.

(3) Health services research.

(4) Basic science research.

(5) Clinical trials.

(6) Other appropriate research and investigational activities.”.

(b) IMPROVING AND PROMOTING ELECTRONIC MEDICAL RECORDS.—

(1) AUTHENTICATION STANDARDS.—The Director of the National Center for Vital and Health Statistics shall provide assistance to the Secretary of Health and Human Services in the development of authentication standards for health records. In developing such standards, the Secretary shall take into consideration the following:

(A) Recommendations for authentication technology and identification information standards that—

(i) provide for the reliable identification and retrieval of a patient’s electronic medical data;

(ii) allow the patient to have detailed control over the access of individual components of his or her electronic medical record by being able to specify specific providers, each of whom will have access to limited portions of the electronic medical record;

(iii) minimize security risks, including the potential for—

(I) the patient to misrepresent his or her true identity;

(II) a health care provider to access data for which the patient has not consented to grant such access;

(III) a third party to access identification information; or

(IV) a third party to circumvent or exploit the authentication process in order to access electronic medical data without the consent of the patient;

(iv) allow for the timely and convenient creation of identification information at the time of contact between a patient and a provider, so as to minimize any disruption or delay in the provision of needed medical services to a patient who does not already have identification information; and

(v) maximize the probability of accurate identification, secure authentication, and rapid access to medical data even in situations where the patient—

(I) does not possess the identification information that is usually required for successful authentication, but wishes to grant consent to the provider to access necessary medical data;

(II) possesses the identification information but is not able to provide consent for the emergency access of medical data due to incapacitation; and

(III) is not able to provide identification information nor consent for emergency data access due to incapacitation.

(2) PERSONAL HEALTH RECORD.—

(A) FEDERAL HEALTH INFORMATION EXCHANGE STANDARDS INITIATIVE.—The Secretary of Health and Human Services, the

Secretary of Defense, and the Secretary of Veterans’ Affairs, in carrying out activities under the Federal e-Government Health Information Exchange Standards Initiative, shall jointly recommend standards for the implementation of personal health records that—

(i) includes the capability for patients to append to their electronic record information about—

(I) illnesses for which the patient did not seek professional medical care; and

(II) health information not related to a specific disease, episode, or illness; and

(ii) provides convenient access to the individual’s full electronic medical record.

(B) MEDICAL TRANSLATION RESEARCH.—

(i) IN GENERAL.—The Director of the National Science Foundation shall award grants to public and nonprofit private entities for the conduct of basic research on innovative approaches to improve patients’ understanding and comprehension of their electronic medical record. Research areas may include technology for the automated—

(I) translation of medical information to language more easily understandable by the patient;

(II) reorganization of the electronic medical record into a structure more useful to the patient; and

(III) integration of links to relevant information from other sources into the electronic medical record.

(ii) MERIT REVIEW; COMPETITION.—Grants shall be awarded under this subparagraph on a merit-reviewed competitive basis.

(iii) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the National Science Foundation to carry out this subparagraph—

(I) \$5,000,000 for fiscal year 2004;

(II) \$10,000,000 for fiscal year 2005; and

(III) \$15,000,000 for fiscal year 2006 and each fiscal year thereafter.

(3) DEFINITIONS.—In this subsection:

(A) IDENTIFICATION INFORMATION.—The term “identification information” with respect to the medical records of a patient, means the data necessary to identify the patient.

(B) AUTHENTICATION.—The term “authentication” means the process of using the identification information to validate the patient’s identification and gain access to his or her electronic medical data.

(c) IMPROVING INFORMATION TECHNOLOGY INFRASTRUCTURE IN THE BASIC LIFE SCIENCES.—Not later than 18 months after the date of enactment of this Act, the Director of the National Institute of General Medical Sciences shall submit to Congress a report on the activities of the Biomedical Information Science and Technology Initiative. Such report shall include—

(1) a description of current activities of the Biomedical Information Science and Technology Initiative Consortium;

(2) a summary of recently completed and ongoing grant programs; and

(3) recommendations for the further advancement of the Biomedical Information Science and Technology Initiative and bioinformatics and computational biology research in general.

(d) IMPROVING EDUCATION AND TRAINING.—Subpart 3 of part D of title IV of the Public Health Service Act (42 U.S.C. 286c et seq.) is amended by adding at the end the following:

“SEC. 478B. CERTIFICATION OF INFORMATION WEBSITES.

“(a) IN GENERAL.—The National Information Center on Health Services Research and Health Care Technology (in this section referred to as the ‘Center’) shall develop a voluntary certification program for health information websites on the Internet. As part of such program, websites shall be deemed to

be certified if they meet criteria that includes the following:

"(1) The website provides references to peer-reviewed rigorous scientific research for any conclusions or recommendations that it advocates.

"(2) The website is easy to navigate and comprehend by a general audience that does not have any specific medical training.

"(3) The website accommodates, to the maximum extent practicable, cultural, language, and literacy variation among its target audience.

"(b) LIMITATION.—In determining whether a website meets criteria for certification under the program under subsection (a), the Center may not consider—

"(1) the specific nature of the conclusions or recommendations of the website themselves, so long as they meet criteria for evidence as specified in subsection (a)(1); and

"(2) the person or organization responsible for the website.

"(c) PERIOD RECERTIFICATION.—In establishing the program under subsection (a), the Center shall develop a policy for the periodic expiration and renewal of certifications so as to ensure that websites are reviewed on a periodic basis for compliance with the criteria of certification.

"(d) SEAL.—The Center shall develop a seal or marker that can be used by a website that is certified under the program under subsection (a) to indicate to its audience that the website has obtained the Center's certification.

"(e) FEE.—The Center may assess an application fee for websites in order to cover the costs of evaluating the website."

SA 1017. Mr. ALLARD (for himself, Mr. FITZGERALD, and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:
SEC. ____ . TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c)

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot

be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SA 1018. Mr. LIEBERMAN (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:
SEC. ____ . COLON CANCER SCREENING.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) colorectal cancer screening tests (as defined in section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)) covered under the medicare program have been severely underutilized, with the Comptroller General of the United States reporting in 2000 that since coverage of such tests was implemented, the percentage of beneficiaries under the medicare program receiving either a screening or a diagnostic colonoscopy has increased by only 1 percent;

(2) the Centers for Medicare & Medicaid Services should encourage health care providers to use more effective screening and diagnostic health care technologies in the area of colorectal cancer screening;

(3) in recent years, the Centers for Medicare & Medicaid Services has subjected colorectal cancer screening tests to some of the largest reimbursement reductions under the medicare program;

(4) unlike other preventive screening tests covered under the medicare program, health care providers must consult with beneficiaries prior to furnishing a screening colonoscopy in order to—

(A) ascertain the medical and family history of the beneficiary; and

(B) inform the beneficiary of preparatory steps that must be taken prior to the procedure; and

(5) reimbursement under the medicare program is not currently available for the consultations described in paragraph (4) despite the fact that reimbursement is provided under such program for similar consultations prior to a diagnostic colonoscopy.

(b) INCREASE IN REIMBURSEMENT FOR COLORECTAL CANCER SCREENING AND DIAGNOSTIC TESTS.—

(1) IN GENERAL.—Section 1834(d) (42 U.S.C. 1395m(d)) is amended by adding at the end the following new paragraph:

"(4) ENHANCED PAYMENT FOR COLORECTAL CANCER SCREENING AND DIAGNOSTIC TESTS.—

"(A) FACILITY RATES.—Notwithstanding paragraphs (2)(A) and (3)(A), the Secretary shall establish national minimum payment amounts for CPT codes 45378, 45380, 45385 and HCPCS codes G0105 and G0121 for items and

services furnished during the last 6 months of 2003 and in subsequent years which reflect a 30 percent increase above the relative value units in effect as the facility rates for such codes on June 30, 2003, with such revised payment level to apply to items and services performed in a facility setting.

"(B) ANNUAL ADJUSTMENTS.—In the case of items and services furnished on or after January 1, 2004, the payment rates described in subparagraph (A) shall, subject to the minimum payment amounts established in such subparagraph, be adjusted annually as provided in section 1848."

(2) EFFECT ON PART A PAYMENTS.—The Secretary shall not consider the national minimum payment described in section 1834(d)(4)(A) (42 U.S.C. 1395m(d)(4)(A)), as added by paragraph (1), when determining the hospital outpatient prospective payment system payment amounts under the relevant APC codes for colorectal cancer screening and diagnostic tests.

(3) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services furnished on or after July 1, 2003.

(c) MEDICARE COVERAGE OF OFFICE VISIT OR CONSULTATION PRIOR TO A SCREENING COLONOSCOPY OR IN CONJUNCTION WITH A BENEFICIARY'S DECISION TO OBTAIN SUCH A SCREENING.—

(1) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by inserting "and" at the end; and

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

"(W) an outpatient office visit or consultation for the purpose of beneficiary education, assuring selection of the proper screening test, and securing information relating to the procedure and sedation of the beneficiary, prior to a colorectal cancer screening test consisting of a screening colonoscopy or in conjunction with the beneficiary's decision to obtain such a screening, regardless of whether such screening is medically indicated with respect to the beneficiary;"

(2) PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) (42 U.S.C. 1395j(a)(1)) is amended—

(i) by striking "and" before "(U)"; and

(ii) by inserting before the semicolon at the end the following: ", and (V) with respect to an outpatient office visit or consultation under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge or the amount established under section 1848, except that no payment shall be made for such a visit or consultation if no payment would be made for a colorectal cancer screening test consisting of a screening colonoscopy for the individual furnished on the date of such visit or consultation because of the frequency limits described in section 1834(d)(3)(E)".

(B) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by inserting "(2)(W)," after "(2)(S)".

(C) REQUIREMENT FOR ESTABLISHMENT OF PAYMENT AMOUNT UNDER PHYSICIAN FEE SCHEDULE.—Section 1834(d) (42 U.S.C. 1395m(d)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

"(5) PAYMENT FOR OUTPATIENT OFFICE VISIT OR CONSULTATION PRIOR TO SCREENING COLONOSCOPY.—With respect to an outpatient office visit or consultation under section 1861(s)(2)(W), payment under section 1848 shall be consistent with the payment amounts for CPT codes 99203 and 99243."

(D) FREQUENCY LIMITATION.—Section 1861(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (H), by striking “and” at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting “, and”; and

(iii) by inserting after subparagraph (I) the following new subparagraph:

“(J) in the case of an outpatient office visit or consultation under section 1861(s)(2)(W), which is performed more frequently than is covered under section 1833(a)(1)(V).”

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services provided on or after July 1, 2003.

(d) WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.—

(1) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395y(b)) is amended—

(A) by striking “and” before “(6)”; and

(B) by inserting before the period at the end the following: “, and (7) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1)).”

(2) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(A) by striking “DEDUCTIBLE AND” in the heading; and

(B) in subclause (I), by striking “deductible or” each place it appears.

(3) EFFECTIVE DATE.—The amendment made by this subsection shall apply to items and services furnished on or after July 1, 2003.

SA 1019. Mr. CONRAD (for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes;

At the end of subtitle B of title IV, insert the following:

SEC. ____ . MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking “and” at the end;

(B) in subparagraph (V), by inserting “and” at the end; and

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

“(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

“(ii) a self-injected drug that is used to treat multiple sclerosis.”

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting “, except for any drug or biological described in subparagraph (W),” after “which”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

At the end of title VI, add the following:

SEC. ____ . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

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

(B) in subparagraph (B)—

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

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

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

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.”; and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received”; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The

United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.”

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

SA 1020. Mr. CONRAD proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Strike section 401 and insert the following:

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 subclause (II), for discharges”; and

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

“(II) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) 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”;

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” 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 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking the period at the end and inserting “; and”;

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

“(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

“(I) the applicable 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.”.

At the end of title VI, add the following:

SEC. ____ . MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

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

(B) in subparagraph (B)—

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

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

“(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

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

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”;

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.”; and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received”;

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or re-

sponsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.”.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

SA 1021. Mr. CONRAD1 proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ____ . GEOGRAPHIC RECLASSIFICATION OF CERTAIN HOSPITALS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2004 and each subsequent fiscal year, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospitals located in the Bismarck, North Dakota Metropolitan Statistical Area are deemed to be located in the Fargo-Moorhead North Dakota-Minnesota Metropolitan Statistical Area.

(b) TREATMENT AS DECISION OF MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD.—

(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(2) NONAPPLICATION OF 3-YEAR APPLICATION PROVISION.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to reclassifications made under this section.

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) ADJUSTMENTS TO ENSURE BUDGET NEUTRALITY.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or

less than those that would otherwise be made if this section had not been enacted.

SA 1022. Mr. BROWBACK submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

SEC. . This Act may be cited as the “Quality Cancer Care Preservation Act”.

SEC. . MEDICARE PAYMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842(o)(1) of the Social Security Act (42 U.S.C. 1395u(o)(1)) is amended by striking “95 percent of the average wholesale price” and inserting “the payment amount specified in section 1834(n)(2)”.

(b) DETERMINATION OF PAYMENT AMOUNT.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(n) PAYMENT FOR DRUGS AND BIOLOGICALS—

“(1) REPORTS BY MANUFACTURERS—

“(A) IN GENERAL.—Every drug manufacturer shall report to the Secretary, in the manner prescribed in this paragraph, its average sales price (as defined in subparagraph (B)) in the United States during each calendar quarter for drugs and biologicals covered under this part.

“(B) DEFINITIONS.—For purposes of this subsection—

“(i) the term “manufacturer” means, with respect to a drug or biological, the entity identified by the Labeler Code portion of the National Drug Code of such drug or biological; and

“(ii) the term “average sales price” means the weighted average of all final sales prices to all purchasers, excluding sales specified in subparagraph (C). In determining such average sales prices, such prices shall be net of volume discounts, chargebacks, short-dated product discounts, free goods contingent on purchases, rebates (other than those made or authorized under section 1927), and all other price concessions that result in a reduction of the ultimate cost to the purchaser.

“(C) CONSIDERATION IN CALCULATION OF AVERAGE SALES PRICES.—The calculation of average sales price under this subsection shall not include—

“(i) prices that are excluded from the calculation of “best price” under section 1927(c)(1)(C);

“(ii) prices offered to entities that are considered under subparagraph (B)(i) to be the manufacturers of the drugs or biologicals involved;

“(iii) prices offered by a manufacturer to a hospital, nursing facility, hospice, or health maintenance organization;

“(iv) prices to governmental entities; and

“(v) nominal prices offered to bona fide charitable organizations.

“(D) QUARTERLY REPORTS.—Each manufacturer shall submit the report required by subparagraph (A) to the Secretary by electronic means no later than 30 days after the end of a calendar quarter with respect to sales that occurred during such quarter. The Secretary shall prescribe the format and other requirements for the report.

“(E) Enforcement.—

“(i) FAILURE TO TIMELY REPORT.—The Secretary may impose a civil monetary penalty in an amount not to exceed \$100,000 on a manufacturer that fails to provide the information required under this paragraph on a timely basis and in the manner required.

“(ii) FALSE INFORMATION.—For each item of false information, the Secretary may impose a civil money penalty in an amount not to exceed \$100,000 on a manufacturer that knowingly provides false information under this paragraph.

“(iii) MANNER OF IMPOSITION OF CIVIL MONETARY PENALTIES.—The provisions in section 1128A (other than subsections (a) and (b)) shall apply to a civil monetary penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(F) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers under this paragraph is confidential and shall not be disclosed by the Secretary in any form other than as specifically authorized by this subsection.

“(2) CALCULATION OF PAYMENT AMOUNT—

“(A) IN GENERAL.—Except as otherwise provided in this paragraph, the payment amount for a drug or biological furnished during a calendar quarter shall be 120 percent of the average sales price of the drug or biological for the second preceding calendar quarter as determined under paragraph (1).

“(B) METHODOLOGY.—In determining payment amounts under subparagraph (A), the Secretary may, in the Secretary’s discretion, use either the average sales price for each drug or biological by specific drug or biological, or a cumulative average sales price based on sales data for all versions of a multiple-source drug that the Secretary, acting through the Food and Drug Administration, has determined are therapeutically equivalent (as evidenced by “A” ratings in the publication Approved Drug Products with Therapeutic Equivalence Evaluations).

“(C) INCREASE TO REFLECT ADDITIONAL COSTS ATTRIBUTABLE TO STATE AND LOCAL TAXES.—In the case of a drug or biological that was subject to a State or local sales tax or gross receipts tax when administered or dispensed, the payment amount determined under subparagraph (A) shall be increased by the amount of such tax paid with respect to such drug or biological.

“(D) SUBSTITUTION OF HIGHER PAYMENT AMOUNT.—If a physician’s, supplier’s, or any other person’s claim for payment for services under this Act documents that the price paid for a drug or biological was greater than the payment amount determined under subparagraph (A), the actual amount paid shall be substituted for the payment amount determined under subparagraph (A), unless the Secretary determines that the actual amount paid was unreasonable under the circumstances.

“(E) INCREASE FOR BAD DEBT AND CERTAIN OTHER COSTS.—Upon the submission of supporting information, the Secretary shall make an additional payment to a physician or supplier to cover—

“(i) uncollectible deductibles and coinsurance due from Medicare beneficiaries with respect to drugs and biologicals furnished to such beneficiaries; and

“(ii) costs incurred in procuring and billing for drugs and biologicals furnished to Medicare beneficiaries.”.

SEC. . MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.

(a) GENERAL.—The Secretary of Health and Human Services (hereafter in this Act referred to as “the Secretary”) shall revise the practice expense relative value units for drug administration services for years beginning with the year 2005 in accordance with this section. For purposes of this section, “drug administration services” includes chemotherapy administration services, therapeutic and diagnostic infusions and injections, and such other services as the Secretary specifies.

(b) DIRECT COSTS EQUAL TO 100 PERCENT OF CPEP ESTIMATES.—Using the information, including estimates of clinical staff time, developed in the clinical practice expert panel process, including refinements by American Medical Association committees, the Secretary shall estimate the costs of the nursing and other clinical staff, supplies, and procedure-specific equipment (exceeding a cost specified by the Secretary) used in furnishing each type of drug administration service. The Secretary shall utilize without revision the minutes of clinical staff time determined in such process. The Secretary shall convert the information from such process to estimated costs by applying the most current available data on staff salary, supply, and equipment costs, and such costs shall be updated to 2005 based on estimated changes in prices since the date of such data.

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

(d) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under subsection (c) to practice expense relative value units for each drug administration service by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(e) UPDATES.—For years after 2005, the relative values determined under subsection (d) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this section.

(f) MULTIPLE PUSHES.—In establishing the payment amounts under this section, the Secretary shall establish the payment amount for intravenous chemotherapy administration by push technique based of the administration of a single drug. The Secretary shall make the same payment for each additional drug administered by push technique during the same encounter, except to the extent that the Secretary finds that the cost of administering additional drugs is less than the cost of administering the first drug.

SEC. . PAYMENTS FOR CHEMOTHERAPY SUPPORT SERVICES.

(a) GENERAL.—Beginning in the year 2005, the Secretary shall recognize and make payments under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for chemotherapy support services furnished incident to physicians’ services. For the purposes of this section, “chemotherapy support services” are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under section 3(b). Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

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

(c) TOTAL COSTS.—The Secretary shall estimate the total practice expenses of chemotherapy support services by assuming that the direct costs for the service determined

under subsection (b) are 33.2 percent of such total practice expenses.

(d) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under subsection (c) to practice expense relative value units for chemotherapy support services by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under section 1848.

(e) UPDATES.—For the years after 2005, the relative values determined under subsection (d) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this section.

SEC. . CANCER THERAPY MANAGEMENT SERVICES.

The Secretary shall recognize and establish a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service work associated with visits and consultations conducted by physicians treating cancer patients compared to typical visits and consultations. The payment amount may vary by the level and type of the related visit or consultation.

SEC. . OTHER SERVICES WITHOUT PHYSICIAN WORK RELATIVE VALUE UNITS.

The Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule established by section 1848 of the Social Security Act (42 U.S.C. 1395w-4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of any one specialty’s services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

SEC. . PHYSICIAN SUPERVISION OF SERVICES.

Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 2, is further amended by adding at the end the following new subsection:

“(o) SUPERVISION REQUIREMENTS.—If the Secretary requires direct supervision of a service by a physician, that supervision requirement may be fulfilled by one or more physicians other than the physician who ordered the service. If the supervising physician is different from the ordering physician for a particular service, the ordering physician may nevertheless bill for such service provided that the medical records for the service involved identify the supervising physician or physicians.”.

SEC. . REPORT TO CONGRESS.

No later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that are projected to be adopted under sections 2, 3, 4, and 5 of this Act.

SEC. . INSTITUTE OF MEDICINE STUDY.

(a) GENERAL.—The Secretary of Health and Human Services shall request the Institute of Medicine to conduct the study described in this section.

(b) BASELINE STUDY.—The first phase of the study shall include the following objectives:

(1) An assessment of the extent to which the current Medicare payment system, prior to implementation of the amendments made by this Act, facilitates appropriate access to

care by cancer patients in the various treatment settings.

(2) The identification of the comprehensive range of services furnished to cancer patients in the outpatient setting, including support services such as psychosocial services and counseling, and recommendations regarding the types of services that ought to be furnished to Medicare patients with cancer.

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

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

(5) The development of a framework for assessing how the amendments made by this act affect the provision of care to Medicare patients with cancer in the various treatment settings.

(c) **SECOND PHASE OF STUDY.**—After the implementation of the amendments made by this Act, the study shall determine whether and how those amendments affected the provision of care to Medicare patients with cancer.

(d) **CONSULTATION.**—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, social workers, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(e) **DUE DATES.**—

(1) The study required by subsection (b) shall be submitted to the Congress and the Secretary of Health and Human Services no later than June 30, 2004.

(2) The study required by subsection (c) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2006.

SEC. 10. EFFECTIVE DATES.

(a) **GENERAL.**—Except as provided in this section, the provisions of this Act shall apply to drugs, biologicals, and services furnished on or after January 1, 2005.

(b) **REPORTS FROM MANUFACTURERS.**—The first report by manufacturers required by the provisions of section 2 shall be submitted no later than October 30, 2004, with respect to sales that occurred in the quarter ending September 30, 2004.

(c) **SUPERVISION OF SERVICES.**—The amendment made by section 7 shall be effective upon enactment.

(d) **SERVICES OTHER THAN DRUG ADMINISTRATION.**—The Secretary shall implement the requirements of section 6 no later than January 1, 2005.

SA 1023. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in subtitle B of title IV, insert the following:

SEC. ____ . DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) **DEMONSTRATION PROJECT.**—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic

conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) **MEDICARE BENEFICIARY DESCRIBED.**—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) **DEMONSTRATION PROJECT SITES.**—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) **LIMITATION ON NUMBER OF PARTICIPANTS.**—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) **DATA.**—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) **REPORT TO CONGRESS.**—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely affects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) **WAIVER AUTHORITY.**—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) **CONSTRUCTION.**—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) **AUTHORIZATION OF APPROPRIATIONS.**—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) **DEFINITIONS.**—In this section:

(1) **MEDICARE BENEFICIARY.**—The term “medicare beneficiary” means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) **HOME HEALTH SERVICES.**—The term “home health services” has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) **ACTIVITIES OF DAILY LIVING DEFINED.**—The term “activities of daily living” means eating, toileting, transferring, bathing, and dressing.

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

SA 1024. Mr. ENSIGN (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. ____ . OUTPATIENT THERAPY CAP REPEAL.

(a) **IN GENERAL.**—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by striking subsection (g).

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on January 1, 2005.

SA 1025. Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ____ . COST-BENEFIT EVALUATION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION II DEMONSTRATION PROJECT AND EXTENSION OF PROJECT AUTHORITY.

(a) **EXTENSION.**—Notwithstanding any other provision of law, the Social Health Maintenance Organization II demonstration project described under section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended, shall be conducted for an additional period of 5 years beginning October 1, 2004 under applicable contractual provisions existing on December 31, 2002. Such demonstration project shall be evaluated by an independent organization in accordance with subsection (b). The report on the evaluation and related recommendations shall be provided as described in subsection (c).

(b) **EVALUATION.**—

(1) **RESEARCH DESIGN.**—The Secretary shall provide for a project research design that includes information on the Medicare beneficiaries who are participating in the project and on other Medicare beneficiaries who are covered under fee-for-service and other Medicare+Choice plans and that allows for an appropriate statistical analysis and evaluation of the demonstration project by an independent organization.

(2) DATA COLLECTION.—The Secretary shall require the Social Health Maintenance Organization II to comply with such data collection and reporting requirements as the Secretary determines necessary in order that the assessments can be made as described under subsection (c)(2); and

(3) DURATION.—The project evaluation period shall last for a period of 3 years.

(c) REPORT.—

(1) IN GENERAL.—The Secretary shall issue to the Congress a final report on the project not later than 9 months after the date of the completion of the evaluation period.

(2) CONTENTS OF REPORT.—The report under paragraph (1) shall include the following:

(A) A description of the demonstration project and the distinguishing characteristics of the Social Health Maintenance Organization II project, including the project's geriatric approach to patient care, extensive care coordination and patient assessments, provision of extended benefits to beneficiaries with targeted health risks, and risk adjusted payment methodology.

(B) An evaluation of—

(i) the cost-effectiveness of the project compared to the comparison group with respect to the extent of any delay or reduction in the incidence or length of stay in nursing homes or similar institutions and the estimated Medicare and Medicaid cost savings relating to such delay or reductions,

(ii) the extent to which the utilization of physician, home health, coordinated care, geriatric, prescription drug, extended care benefits and other services which are unique to the project result in any reduction in the incidence or length of inpatient stays and in the improvement or lessening in the deterioration of the physical status and mental health functioning of beneficiaries, and

(iii) the feasibility of replicating the elements of the Social Health Maintenance Organization II model under other Medicare+Choice plans.

To the extent feasible, an evaluation of the elements described in this subparagraph shall be conducted on a longitudinal basis for noninstitutionalized beneficiaries who are at high risk of hospitalization or institutionalization, for other noninstitutionalized beneficiaries who are not at high risk, and for institutionalized beneficiaries. To the extent feasible such evaluations shall be conducted for appropriate age and gender beneficiary categories.

(C) A description of the data and criteria and methodology used in conducting the evaluation.

(D) Any other information regarding the project that the Secretary determines to be appropriate and any recommendations the Secretary may make regarding the extent to which changes should be made in connection with the project or the extension of the project as a model under the Medicare+Choice program.

(d) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term "demonstration project" means the demonstration project described under subsection (a).

(2) MEDICARE BENEFICIARY.—The term "Medicare beneficiary" means an individual entitled to benefits under part A and covered under part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) MEDICARE.—The term "Medicare" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) MEDICARE+CHOICE.—The term "Medicare+Choice" means the Medicare+Choice health benefits program described under part C of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and

for years after 2005, the Medicare Advantage program described under such part.

(5) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(6) SOCIAL HEALTH MAINTENANCE ORGANIZATION II.—The term "Social Health Maintenance Organization II" means the project described under section 2355(b)(1)(B) of the Deficit Reduction Act of 1984, as amended.

(e) EFFECTIVE DATE.—The effective date of this section is the date of the enactment of this Act.

SA 1026. Mr. HAGEL (for himself, Mr. ENSIGN, Mr. LOTT, and Mr. INHOFE) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

(Purpose: To provide medicare beneficiaries with a drug discount card that ensures access to privately-negotiated discounts on drugs and protection against high and out-of-pocket drug costs)

Strike title I and insert the following:

TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT

SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

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

"PART D—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

"DEFINITIONS

"SEC. 1860. In this part:

"(1) COVERED DRUG.—

"(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered drug' means—

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

"(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or 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.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered 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 appealed under section 1860D(a)(4)(B).

"(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or Medicare+Choice 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(a)(4).

"(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

"(A) eligible for benefits under part A or enrolled under part B; and

"(B) not eligible for prescription drug coverage under a State plan under the medicare program under title XIX.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

"(A) pharmaceutical benefit management company;

"(B) wholesale pharmacy delivery system;

"(C) retail pharmacy delivery system;

"(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

"(E) Medicare+Choice organization;

"(F) State (in conjunction with a pharmaceutical benefit management company);

"(G) employer-sponsored plan;

"(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

"(I) combination of the entities described in subparagraphs (A) through (H).

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

"(5) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

"ESTABLISHMENT OF PROGRAM

"SEC. 1860A. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

"(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

"(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

"(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

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

"(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

"ENROLLMENT

"SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

“(1) ESTABLISHMENT OF PROCESS.—

“(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

“(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive the benefits under this part.

“(2) ENROLLMENT PERIODS.—

“(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary’s initial enrollment period under part B (as determined under section 1837).

“(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

“(C) OPEN ENROLLMENT PERIOD IN 2005 FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

“(i) enroll under this part; or

“(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

“(3) PERIOD OF COVERAGE.—

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

“(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) 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.

“(4) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

“(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual’s coverage under this part if the individual is—

“(i) no longer enrolled in part A or B; or

“(ii) eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

“(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

“(i) the termination of coverage under part A or (if later) under part B; or

“(ii) the coverage under title XIX.

“(B) ENROLLMENT WITH ELIGIBLE ENTITY.—

“(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

“(2) ELECTION PERIODS.—

“(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the cov-

erage election periods under the Medicare+Choice program under section 1851(e), including—

“(i) annual coordinated election periods; and

“(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

“(B) INITIAL ELECTION PERIODS.—

“(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2005, there shall be an initial election period of 6 months beginning on that date.

“(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

“(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

“(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

“(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

“(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

“(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity per year.

“(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

“(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

“(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan.

“(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care

for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

“(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN 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)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

“(F) VETERANS’ COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

“(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

“PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

“SEC. 1860C. (a) ACTIVITIES.—The Secretary shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug card plans offered by eligible entities with a contract under this part.

“(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

“ENROLLEE PROTECTIONS

“SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

“(1) GUARANTEED ISSUANCE AND NON-DISCRIMINATION.—

“(A) GUARANTEED ISSUANCE.—

“(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

“(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

“(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

“(2) DISCLOSURE OF INFORMATION.—

“(A) INFORMATION.—

“(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

“(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

“(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.

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

“(III) Information on grievance and appeals procedures.

“(IV) Information on enrollment fees and prices charged to the enrollee for covered drugs.

“(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

“(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

“(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

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

“(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

“(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section

1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card 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.

“(4) APPEALS.—

“(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary 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) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered drug that is not on a formulary of the eligible entity 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.

“(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

“(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

“(1) ACCESS TO COVERED BENEFITS.—

“(A) ASSURING PHARMACY ACCESS.—

“(i) IN GENERAL.—The eligible entity offering the prescription drug discount card 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 Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

“(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card 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) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

“(B) USE OF STANDARDIZED TECHNOLOGY.—

“(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section

1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

“(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). Such standards shall be compatible with standards established under part C of title XI.

“(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan uses a formulary, the following requirements must be met:

“(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

“(ii) 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.

“(iii) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

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

“(v) 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 physicians.

“(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see paragraphs (3) and (4) of section 1860D(a).

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

“(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs—

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

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

“(iii) 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.

“(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

“(i) 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 ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

“(i) 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.

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

“(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

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

“(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

“(ii) Subsection (c)(1) (relating to access to covered benefits).

“(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

“(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card 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 drug covered under the plan that is therapeutically equivalent and bioequivalent.

“ANNUAL ENROLLMENT FEE

“SEC. 1860E. (a) AMOUNT.—

“(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of \$25.

“(2) ANNUAL PERCENTAGE INCREASE.—

“(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment.

“(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

“(i) the average per capita aggregate expenditures for covered drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year; exceeds

“(ii) such aggregate expenditures for the 12-month period ending with July 2005.

“(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of

\$1, such increase shall be rounded to the nearest multiple of \$1.

“(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

“(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

“(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

“(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

“BENEFITS UNDER THE PROGRAM

“SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.—

“(1) NEGOTIATED PRICES.—

“(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term ‘prescription drugs’ is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

“(B) LIMITATIONS.—

“(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

“(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

“(2) DISCOUNT CARD.—The Secretary shall develop a uniform standard card format to be issued by each eligible entity offering a prescription drug discount card plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

“(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

“(b) CATASTROPHIC BENEFIT.—

“(1) TEN PERCENT COST-SHARING.—Subject to any formulary used by the prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits with cost-sharing that is equal to 10 percent of the negotiated price (taking into account

any applicable discounts) of each drug dispensed to such beneficiary after the beneficiary has incurred costs (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in paragraph (2).

“(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

“(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as determined under section 1860I) is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to \$1,500.

“(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the annual out-of-pocket limit is equal to \$3,500.

“(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the annual out-of-pocket limit is equal to \$5,500.

“(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose income (as so determined) equals or exceeds 600 percent of the poverty line, the annual out-of-pocket limit is an amount equal to 20 percent of that beneficiary’s income for that year (rounded to the nearest multiple of \$1).

“(3) APPLICATION.—In applying paragraph (2), incurred costs shall only include those expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

“(4) ANNUAL PERCENTAGE INCREASE.—

“(A) IN GENERAL.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to—

“(i) such dollar amount; multiplied by

“(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

“(B) ROUNDING.—If any increase determined under subparagraph (A) is not a multiple of \$1, such increase shall be rounded to the nearest multiple of \$1.

“(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

“(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

“(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

“(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

“REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

“SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits

under this part to eligible beneficiaries in an area.

“(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

“(c) ADMINISTRATIVE FEE BID.—

“(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

“(2) BID SUBMISSION REQUIREMENTS.—

“(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

“(i) Enrollment, including income eligibility determination.

“(ii) Claims processing.

“(iii) Quality assurance, including drug utilization review.

“(iv) Beneficiary and pharmacy customer service.

“(v) Coordination of benefits.

“(vi) Fraud and abuse prevention.

“(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

“(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through 1 or both of the following:

“(i) Additional fees charged to the beneficiary, not to exceed \$25 annually.

“(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

“(d) AWARDING OF CONTRACTS.—

“(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

“(2) TERMS AND CONDITIONS.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with such terms and conditions as the Secretary shall specify.

“(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

“(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

“(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

“(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and services to prevent adverse drug interactions.

“(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

“(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

“(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

“(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

“(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health 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.

“(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section 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).

“(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

“(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

“(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits under this section shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Secu-

rity Act of 1974 that apply with respect to such plan.

“PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

“SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

“(1) the costs of providing covered drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b) minus the amount of any cost-sharing collected by the eligible entity under section 1860F(b); and

“(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

“(b) PAYMENT FOR COVERED DRUGS.—

“(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may only pay an eligible entity for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

“(2) LIMITATIONS.—

“(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

“(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

“(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

“(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

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

“DETERMINATION OF INCOME LEVELS

“SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

“(1) IN GENERAL.—The Secretary shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

“(2) PROCEDURES.—The procedures established under paragraph (1) shall require each eligible beneficiary to submit such information as the eligible entity requires to make the determination described in paragraph (1).

“(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary shall—

“(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

“(2) require, if the Secretary determines that payments were made under this part to which an eligible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

“(c) QUALITY CONTROL SYSTEM.—

“(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

“(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

“APPROPRIATIONS

“SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

“MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

“SEC. 1860K. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the ‘Board’).

“(b) ADVICE ON POLICIES; REPORTS.—

“(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Voluntary Medicare Prescription Drug Discount and Security Program under this part.

“(2) REPORTS.—

“(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary 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 the program under this part. Each such report shall be published in the Federal Register.

“(B) 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.

“(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

“(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

“(A) PRESIDENTIAL APPOINTMENTS.—

“(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

“(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

“(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) 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.

“(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

“(2) 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, experience, and attainments, excep-

tionally qualified to perform the duties of members of the Board.

“(3) COMPOSITION.—Of the members appointed under paragraph (1)—

“(A) at least 1 shall represent the pharmaceutical industry;

“(B) at least 1 shall represent physicians;

“(C) at least 1 shall represent medicare beneficiaries;

“(D) at least 1 shall represent practicing pharmacists; and

“(E) at least 1 shall represent eligible entities.

“(d) TERMS OF APPOINTMENT.—

“(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

“(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

“(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

“(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

“(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

“(I) 2 years;

“(II) 4 years; and

“(III) 6 years.

“(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

“(I) 3 years; and

“(II) 6 years.

“(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

“(I) 4 years; and

“(II) 5 years.

“(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

“(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

“(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member's term is less than 4 years, for such remainder.

“(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

“(g) MEETINGS.—

“(1) IN GENERAL.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to consider a specific agenda of issues, as determined by the Chairperson in consultation with the other members of the Board.

“(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

“(h) FEDERAL ADVISORY COMMITTEE ACT.—The Board shall be exempt from the provisions of the Federal Advisory Committee Act (5 U.S.C. App.).

“(i) PERSONNEL.—

“(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

“(2) STAFF.—

“(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

“(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

“(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

“(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

“(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.”.

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

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

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 102. ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) **ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.**—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) **DUTIES.**—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

(c) **DIRECTOR.**—

(1) **APPOINTMENT.**—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) **RESPONSIBILITIES.**—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) **PERSONNEL.**—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

SEC. 103. EXCLUSION OF PART D 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”;

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

“(2) the Voluntary Medicare Prescription Drug Discount and Security Program under part D.”.

SEC. 104. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(v) **MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.**—

“(1) **PROMULGATION OF MODEL REGULATION.**—

“(A) **NAIC MODEL REGULATION.**—If, within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of Insurance Commissioners (in this subsection referred to as the ‘NAIC’) changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as ‘J’ under the standards established by subsection (p)(2) (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) so that—

“(i) the coverage for prescription drugs available under such benefit package is replaced with coverage for prescription drugs that complements but does not duplicate the benefits for prescription drugs that beneficiaries are otherwise entitled to under this title;

“(ii) a uniform format is used in the policy with respect to such revised benefits; and

“(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2003;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy

holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ‘2006 NAIC Model Regulation’).

“(B) **REGULATION BY THE SECRETARY.**—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the ‘2006 Federal Regulation’).

“(C) **CONSULTATION WITH WORKING GROUP.**—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

“(D) **MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.**—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

“(2) **CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.**—Nothing in the benefit packages classified as ‘A’ through ‘I’ under the standards established by subsection (p)(2) (including the benefit package classified as ‘F’ with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

“(3) **APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.**—

“(A) **APPLICATION OF PROVISIONS.**—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

“(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation; and

“(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

“(B) **OTHER REFERENCES.**—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.”.

SA 1027. Ms. SNOWE submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ____ . SENSE OF THE SENATE REGARDING IMPLEMENTATION OF THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003.

(a) **IN GENERAL.**—It is the sense of the Senate that the Committee on Finance of the Senate should hold not less than 4 hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003 (hereinafter in this section referred to as the “Act”) during which the Secretary or his designee should testify before the Committee.

(b) **INITIAL HEARING.**—It is the sense of the Senate that the first hearing described in subsection (a) should be held not later than 60 days after the date of the enactment the Act. At the hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) The progress toward implementation of the prescription drug discount card under section 111 of the Act.

(2) Development of the blueprint that will direct the implementation of the provisions of the Act, including the implementation of title I (Medicare Prescription Drug Benefit), title II (Medicare Advantage), and title III (Center for Medicare Choices) of the Act.

(3) Any problems that will impede the timely implementation of the Act.

(4) The overall progress toward implementation of the Act.

(c) **SUBSEQUENT HEARINGS.**—It is the sense of the Senate that the additional hearings described in subsection (a) should be held in each of May 2004, October 2004, and May 2005. At each hearing, the Secretary or his designee should submit written testimony and testify before the Committee on Finance of the Senate on the following issues:

(1) Progress on implementation of title I (Medicare Prescription Drug Benefit), title II (Medicare Advantage), and title III (Center for Medicare Choices) of the Act.

(2) Any problems that will impede timely implementation of the Act.

SA 1028. Mr. CRAIG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title II, add the following:

SEC. ____ . ESTABLISHMENT OF MEDICARE ADVANTAGE CONSUMER-DRIVEN HEALTH PLAN OPTION.

(a) **PROGRAM SPECIFICATIONS.**—Part C of title XVIII (42 U.S.C. 1395w-21 et seq.), amended by section 205, is amended by inserting after section 1858A the following new section:

“CONSUMER-DRIVEN HEALTH PLAN OPTION

“SEC. 1858B. (a) **ESTABLISHMENT OF PROGRAM.**—

“(1) **IN GENERAL.**—Beginning on January 1, 2006, there is established a consumer-driven health plan program under which consumer-driven health plans offered by consumer-driven health plan sponsors are offered to Medicare Advantage eligible individuals in preferred provider regions.

“(2) **DEFINITIONS.**—

“(A) **CONSUMER-DRIVEN HEALTH PLAN SPONSOR.**—The term ‘consumer-driven health plan sponsor’ means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to consumer-driven health plan sponsors.

“(B) **CONSUMER-DRIVEN HEALTH PLAN.**—The term ‘consumer-driven health plan’ means a Medicare Advantage plan that—

“(i) provides 100 percent coverage for preventive benefits (as defined by the Secretary);

“(ii) includes a personal care account from which enrollees must pay out-of-pocket costs until the deductible is met; and

“(iii) has a high deductible (as determined by the Secretary).

“(C) PREFERRED PROVIDER REGION.—The term ‘preferred provider region’ has the meaning given that term under section 1858(a)(2)(C).

“(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 consumer-driven health plans offered by a consumer-driven health plan sponsor.

“(2) SERVICE AREA.—The service area of a consumer-driven health plan shall be a preferred provider region.

“(3) AVAILABILITY.—Each consumer-driven health plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

“(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

“(5) ASSURING ACCESS TO SERVICES IN CONSUMER-DRIVEN HEALTH PLANS.—The requirements of section 1858(a)(5) shall apply to consumer-driven health plans.

“(6) PERSONAL CARE ACCOUNTS.—

“(A) ESTABLISHMENT.—Each consumer-driven health plan shall establish a personal care account on behalf of each enrollee from which such enrollee shall be required to pay out-of-pocket costs until the deductible described in subsection (a)(2)(B)(iii) is met.

“(B) ROLLOVER.—Subject to subparagraph (C), any amounts remaining in a personal care account at the end of a year shall be credited to such an account for the subsequent year.

“(C) CHANGES OF ELECTION.—If, after electing a consumer-driven health plan, a beneficiary elects a plan under this part that is not a consumer-driven health plan during a subsequent year or elects to receive benefits under the original medicare fee-for-service program option (whether or not as a result of circumstances described in section 1851(e)(4)), any amounts remaining in the account as of the date of such election shall be credited to the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in such proportion as the Secretary determines is appropriate.

“(c) PAYMENTS TO CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

“(1) PAYMENTS TO ORGANIZATIONS.—

“(A) MONTHLY PAYMENTS.—

“(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsections (e) and (i), and section 1859(e)(4), the Secretary shall make, to each consumer-driven health plan sponsor, 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 consumer-driven health 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) APPLICATION OF PREFERRED PROVIDER BENCHMARKS.—The benchmark amounts calculated under section 1858(c)(2) shall apply with respect to consumer-driven health plans.

“(3) APPLICATION OF PREFERRED PROVIDER PAYMENT FACTORS.—The provisions of section 1858(c)(3) shall apply with respect to consumer driven health plans.

“(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).

“(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The preferred provider regional benchmark calculated under section 1858(c)(4)(B) shall apply with respect to consumer-driven health plans 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).

“(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 consumer-driven health plan sponsor for a consumer-driven health 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 section 1858(c)(3)(A)(ii).

“(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR CONSUMER-DRIVEN HEALTH PLAN SPONSORS 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 consumer-driven health plan sponsors in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

“(5) PAYMENTS FROM TRUST FUND.—The payment to a consumer-driven health plan sponsor 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 consumer-driven health plan sponsors.

“(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to consumer-driven health plan sponsors.

“(d) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLANS; PREMIUMS.—

“(1) SUBMISSION OF BIDS BY CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—

“(A) IN GENERAL.—For the requirements on submissions by consumer-driven health plans, see section 1854(a)(1).

“(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a consumer-driven health 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 consumer-driven health 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 consumer-driven health plan sponsor with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

“(E) NO LIMIT ON NUMBER OF PLANS IN A REGION.—The Secretary may not limit the number of consumer-driven health plans offered in a preferred provider region.

“(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a consumer-driven health plan offered by a consumer-driven health plan sponsor 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 consumer-driven health plan sponsors.

“(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a consumer-driven health plan sponsor 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 consumer-driven health plan sponsor offering a consumer-driven health 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 consumer-driven health 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 consumer-driven health plan sponsor 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 consumer-driven health plan sponsor 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) 10 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 consumer-driven health plan sponsor 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) 10 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 consumer-driven health 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 consumer-driven health plan offered by a consumer-driven health plan sponsor 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 consumer-driven health plan sponsor that offers a consumer-driven health 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 consumer-driven health plan sponsor

and a consumer-driven health 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 CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—A consumer-driven health plan sponsor 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 consumer-driven health plan.

“(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to consumer-driven health plan sponsors.

“(h) CONTRACTS WITH CONSUMER-DRIVEN HEALTH PLAN SPONSORS.—The provisions of section 1857 shall apply to a consumer-driven health plan offered by a consumer-driven health plan sponsor under this section.

“(i) BUDGET NEUTRALITY.—Notwithstanding any other provision of this section, in conducting the program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under this title do not exceed the amount the Secretary would have paid if this section had not been enacted.”

(b) CONSUMER-DRIVEN HEALTH PLAN TERMINOLOGY DEFINED.—Section 1859(a) (42 U.S.C. 1395w-29(a)), as amended by section 211(b), is amended by adding at the end the following new paragraph:

“(4) CONSUMER-DRIVEN HEALTH PLAN SPONSOR; CONSUMER-DRIVEN HEALTH PLAN.—The terms ‘consumer-driven health plan sponsor’ and ‘consumer-driven health plan’ have the meaning given such terms in section 1858B(a)(2).”

SA 1029. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:
SEC. . . . MEDICARE COVERAGE OF CRITICAL ACCESS HEALTH CENTER SERVICES.

(a) IN GENERAL.—

(1) COVERAGE.—Section 1861(s)(2)(E) (42 U.S.C. 1395x(s)(2)(E)) is amended—

(A) by striking “services and” and inserting “services;” and

(B) by striking “center services” and inserting “center services, and critical access health center services”.

(2) DEFINITIONS.—Section 1861(aa) (42 U.S.C. 1395x(aa)) is amended—

(A) in the heading—

(i) by striking “Services and” and inserting “Services;” and

(ii) by striking “Center Services” and inserting “Center Services, and Critical Access Health Center Services”;

(B) in paragraph (1)(B), by striking “paragraph (5)” and inserting “paragraph (7)”;

(C) by redesignating paragraphs (5), (6), and (7) as paragraphs (7), (8), and (9), respectively; and

(D) by inserting after paragraph (4) the following:

“(5) The term ‘critical access health center services’ means—

“(A) services of the type described in subparagraphs (A) through (C) of paragraph (1); and

“(B) preventive primary health services of the type that a health center is required to provide under section 330 of the Public Health Service Act,

when furnished to an individual who is an outpatient of a critical access health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a critical access health center or a physician at the center, respectively.

“(6) The term ‘critical access health center’ means an entity that—

“(A) is sponsored by a private, nonprofit entity with a religious affiliation; and

“(B) based on the recommendation of the Centers for Medicare and Medicaid Services, is determined by the Secretary to meet the requirements for receiving a grant under section 330 of the Public Health Service Act (other than the requirement of subsection (n)(3)(H)(i) of such section).”.

(3) PAYMENTS.—

(A) SCOPE OF BENEFITS.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(i) in paragraph (1), by striking “subparagraphs (B) and (D)” and inserting “subparagraphs (B), (D), and (K)”; and

(ii) in paragraph (2)—

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

(II) by striking the period at the end of subparagraph (J) and inserting “; and”; and

(III) by adding at the end the following:

“(K) critical access health center services.”.

(B) PAYMENT OF BENEFITS.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(i) in the matter preceding subparagraph (A) of paragraph (2), by striking “and (I)” and inserting “(I), and (K)”; and

(ii) in paragraph (3), by inserting “or section 1832(a)(2)(K)” after “section 1832(a)(2)(D)”.

(C) PART B DEDUCTIBLE NOT APPLICABLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended by inserting “or critical access health center services” after “Federally qualified health center services”.

(D) EXCEPTION TO EXCLUSIONS FROM COVERAGE.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (2), by inserting “or critical access health center services (as defined in section 1861(aa)(5))” after “Federally qualified health center services”; and

(ii) in paragraph (3), by inserting “in the case of critical access health center services (as defined in section 1861(aa)(5)),” after “section 1880(e).”; and

(iii) in the second sentence, by inserting “or critical access health center services described in section 1861(aa)(5)(B)” after “section 1861 (aa)(3)(B)”.

(E) EXCEPTION TO ANTI-KICKBACK LAW FOR WAIVER OF COINSURANCE.—Section 1128B(b)(3)(D) (42 U.S.C. 13206-7b(b)(3)(D)) is amended—

(i) by inserting “(i)” before “a waiver”;

(ii) by inserting “and” after “Act.”; and

(iii) by adding at the end the following:

“(i) a waiver of—

“(I) any coinsurance under part B of title XVIII by a critical access health center with respect to an individual who qualifies for subsidized services under a provision of section 330 of the Public Health Service Act (as made applicable to such centers by section 1861(aa)(6)); and

“(II) the deductible and any coinsurance under such part by any provider of services, physician, or supplier to which such an individual is referred by a critical access health center for the provision of services that are not critical access health center services;”.

(F) CONFORMING AMENDMENTS.—

(i) Section 1842(b)(18)(C)(1) (42 U.S.C. 1395u(b)(18)(C)(1)) is amended by striking “section 1861(aa)(5)” and inserting “section 1861(aa)(7)”.

(ii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended in subparagraph (H)(i), by strik-

ing “subsection (aa)(5)” and inserting “subsection (aa)(7)”.

(iii) Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended in subparagraph (K)—

(I) by striking “subsection (aa)(5)” each place it appears and inserting “subsection (aa)(7)”; and

(II) by striking “subsection (aa)(6)” and inserting “subsection (aa)(8)”.

(b) EFFECTIVE DATE.—The amendments made this section shall apply to items and services furnished on or after October 1, 2004.

SEC. ____ . DEMONSTRATION TO IMPROVE ACCESS AND CONTINUITY OF CARE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—The Secretary shall—

(1) conduct a demonstration project to test the use of alternative payment methodologies to health care providers to improve access to ambulatory health care services and continuity of care for vulnerable populations such as low-income beneficiaries under title XVIII; and

(2) waive any provisions of the Social Security Act that are necessary to implement such demonstration.

(b) DURATION.—The demonstration project conducted pursuant to subsection (a) shall be for a term of at least 3 years and shall begin operation not later than 1 year after the date of the enactment of this Act.

(c) REPORTS.—

(1) INTERIM AND FINAL REPORTS REQUIRED.—The Secretary shall submit interim and final reports on the demonstration project conducted pursuant to subsection (a) to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives. Such reports shall describe—

(A) the alternative payment methodologies in use under the demonstration;

(B) the provisions of law waived by the Secretary in order to conduct the demonstration; and

(C) the extent to which the demonstration has achieved the objectives described in subsection (a).

(2) TIMING OF REPORTS.—The Secretary shall submit the interim report required by paragraph (1) not later than 2 years after the commencement of the demonstration and the final report not later than 6 months after the termination of the demonstration.

SA 1030. Mr. ENZI submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 356, strike lines 8 through 11, and insert the following:

“(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting—

“(i) the persons from whom enrollees under such plan may obtain covered benefits; or

“(ii) the categories of licensed health professionals or providers from whom enrollees under such a plan may obtain covered benefits if the covered services are provided to enrollees in a State where 25 percent or more of the population resides in health professional shortage areas designated pursuant to section 332 of the Public Health Service Act.”

SA 1031. Mr. CARPER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug

coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ____ . INCREASING TYPES OF ORIGINATING TELEHEALTH SITES AND FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclauses:

“(VI) A skilled nursing facility (as defined in section 1819(a)).

“(VII) An assisted-living facility (as defined by the Secretary).

“(VIII) A board-and-care home (as defined by the Secretary).

“(IX) A county of community health clinic (as defined by the Secretary).

“(X) A community mental health center (as described in section 1861(ff)(2)(B)).

“(XI) A long-term care facility (as defined by the Secretary).

“(XII) A facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) directly, or under contract or other arrangement.”.

(b) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—

(1) IN GENERAL.—For purposes of expediting the provision of telehealth services for which payment is made under the medicare program under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), across State lines, the Secretary shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of State provisions allowing for multistate practitioner licensure across State lines.

(2) DEFINITIONS.—In this subsection:

(A) TELEHEALTH SERVICE.—The term “telehealth service” has the meaning given that term in subparagraph (F)(i) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(B) PHYSICIAN, PRACTITIONER.—The terms “physician” and “practitioner” have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(C) MEDICARE PROGRAM.—The term “medicare program” means the program of health insurance administered by the Secretary under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SA 1032. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ____ . PERMITTING DIRECT PAYMENT UNDER THE MEDICARE PROGRAM FOR CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting “clinical social worker services,” after “qualified psychologist services.”.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) (42 U.S.C. 1395x(hh)(2)) is amended by striking “and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2003.

SA 1033. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:
SEC. ____ EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b-1 note), as previously amended, is amended by striking "December 31, 2004, but only with respect to" and all that follows and inserting "December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996."

SA 1034. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ____ EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(i) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) CANCER HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(v), for covered OPD services 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.

"(II) CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii), for covered OPD services furnished before October 1, 2003, and 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. In the case of such a hospital, for such services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions incurred in furnishing such services, the amount of payment under this subsection shall be increased by the amount of such difference."

SA 1035. Ms. MIKULSKI submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. ____ EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(t)(7)(D)(ii) (42 U.S.C. 1395l(t)(7)(D)(ii)) is amended to read as follows:

"(i) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of a hospital described in clause (iii) or (v) of section 1886(d)(1)(B), for covered OPD services 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.

"(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State with a reimbursement system under section 1814(b)(3), but that is not reimbursed under such system, for covered OPD services furnished on or after October 1, 2003, and for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in providing such services, the amount of payment under this subsection shall be increased by the amount of such difference."

SA 1036. Mr. REID (for Mrs. BOXER) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 53, between line 8 and 9, insert the following:

"(6) NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

"(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

"(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.
"(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D-19(a).

"(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D-16 that are necessary because of the rules under subparagraph (A)."

SA 1037. Mr. REID (for Mr. CORZINE) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:
SEC. ____ CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) PERMITTING FQHCs TO FILL PRESCRIPTIONS.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking "and" after the comma at the end;
(2) in subparagraph (B), by inserting "and" after the comma at the end; and
(3) by adding at the end the following new subparagraph:

"(C) drugs and biologicals for which payment may otherwise be made under this title,".

(b) ELIMINATION OF PER VISIT LIMIT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amend-

ed by inserting ", except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C)" after "the Secretary may prescribe in regulations".

SA 1038. Mr. REID (for Mr. JEFFORDS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of section 405 add the following:
(g) EXCLUSION OF CERTAIN BEDS FROM BED COUNT AND REMOVAL OF BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395l-4(c)(2)) is amended by adding at the end the following:

"(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25."

(2) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITALS.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking "a distinct part of the hospital (as defined by the Secretary)" in the matter following cause (v) and inserting "a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

SA 1039. Mr. REID (for Mr. INOUE) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Native Hawaiian Medicaid Coverage Act of 2003".

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting ", and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider" before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

SA 1040. Mr. SCHUMER (for himself, Mr. CORZINE, Mrs. CLINTON, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 294, line 6, strike “or (C)” and insert “(C), or (D)”.

On page 294, line 21, insert “(other than in 2004 and 2005)” after “multiplied”.

On page 297, strike lines 5 through 9, and insert the following:

“(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(D) ANNUAL FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—For 2004 and 2005, the adjusted average per capita cost for the year, as determined under section 1876(a)(4) for the Medicare+Choice payment area for items and services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B and not enrolled in a Medicare+Choice plan under this part for the year, except that such amount shall be adjusted—

“(i) to exclude costs attributable to payment adjustments described in subsection (a)(5)(B)(ii), and

“(ii) to include an amount equal to the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 298, line 10, strike “subparagraph (B)” and insert “subparagraphs (B) and (E)”.

On page 301, between lines 8 and 9, insert the following:

“(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

On page 302, line 23, insert “(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)” after “medicare beneficiaries”.

On page 303, line 9, insert “(other than 2004 and 2005)” after “for each year”.

On page 349, between lines 4 and 5, insert the following:

(3) PAYMENT RATES BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN 2004 AND 2005.—

(A) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w-23(c)) is amended—

(i) in paragraph (1)(A), in the flush matter following clause (ii), by inserting “(other than in 2004 and 2005)” after “multiplied”; and

(ii) in paragraph (5), by inserting “(other than 2004 and 2005)” after “for each year”.

(B) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)) is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (E)”; and

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

“(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for 2004 and 2005, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.”.

(C) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-23(c)(4)(B)(i)(II)) is amended by inserting “(or, in the case of calculations for payments for months beginning on or after January 1, 2004, and before December 31, 2005, the average number of medicare beneficiaries enrolled in a Medicare+Choice plan that are)” after “medicare beneficiaries”.

(D) UPDATE IN MINIMUM PERCENTAGE INCREASE.—Section 1853(c)(1)(C) (42 U.S.C. 1395w-23(c)(1)(C)) is amended by striking clause (iv) and inserting the following new clauses:

“(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(v) For 2004 and 2005, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(vi) For 2006 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.”.

SA 1041. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural

areas of Alaska are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms “hospital” and “critical access hospital” have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1042. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. . . TREATMENT OF PHYSICIANS’ SERVICES FURNISHED IN ALASKA.

Section 1848(b) (42 U.S.C. 1395w-4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”; and

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

“(4) TREATMENT OF PHYSICIANS’ SERVICES FURNISHED IN ALASKA.—

“(A) IN GENERAL.—With respect to physicians’ services furnished in Alaska on or after January 1, 2004, and before January 1, 2014, the fee schedule for such services shall be determined as follows:

“(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

“(I) in the case of services furnished in calendar year 2004, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

“(II) in the case of services furnished in each of calendar years 2005 through 2013, the amount determined under this clause for the previous year, increased by the annual update determined under subsection (d) for the year involved.

“(ii) In the case of a service for which there was no VA Alaska fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to the sum of—

“(I) the amount of payment for the service that would otherwise apply under this section; plus

“(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

“(B) VA ALASKA FEE SCHEDULE AMOUNT.—For purposes of this paragraph, the term ‘VA Alaska fee schedule amount’ means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians’ services associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical

services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38.

“(C) APPLICABLE PERCENT.—For purposes of this paragraph, the term ‘applicable percent’ means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount for physicians’ services exceeded the amount of payment for such services under this section that applied in Alaska in 2001.”

SA 1043. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 377, between lines 12 and 13, insert the following:

“(I) Section 1851(d) (relating to the provision of information to promote informed choice).

“(J) Section 1851(h) (relating to the approval of marketing material and application forms).

“(K) Section 1852(e)(4) (relating to treatment of accreditation).

“(L) Section 1857(i) (relating to Medicare+Choice program compatibility with employer or union group health plans).”

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. COCHRAN. Mr. President, I announce that the Committee on Agriculture, Nutrition, and Forestry will conduct a hearing on June 26, 2003 in SR-328A at 9 a.m. The purpose of this meeting will be to review H.R. 1904, The Healthy Forests Restoration Act of 2003.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 24, 2003, at 10 a.m. to conduct a hearing on “Bus Rapid Transit and Other Bus Service Innovations.”

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Tuesday, June 24, 2003, at 9:30 a.m. on Reform of the USOC.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Com-

mittee on Energy and Natural Resources be authorized to meet during the session of the Senate on Tuesday, June 24 at 10 a.m. in room SD-366. The purpose of this oversight hearing is to receive testimony on issues associated with changes in the relationship between the U.S. Department of Energy and the contractors operating its National Laboratories, other laboratories and sites.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, June 24, 2003 at 2:30 p.m. to hold a hearing on U.S. Relations With A Changing Europe: Differing Views on Technology Issues.

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

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Tuesday, June 24, 2003, at 10 a.m. for a hearing entitled “Controlling the Costs of Federal Health Programs by Curing Diabetes: A Case Study.”

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

COMMITTEE ON THE JUDICIARY

Mr. SUNUNU. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on Tuesday, June 24, 2003, at 9:30 a.m. in SDG 50.

Agenda

1. Indexing All Awards for Future Inflation: This amendment indexes claim award values to inflation.

2. Removing Collateral Source Offsets: This amendment ensures that more money will go to claimants by striking all existing collateral source offsets in the bill except for compensation from past settlements and judgments for the same asbestos-related injury.

3. Doubling the Statute of Limitations: This amendment doubles the statute of limitations from 2 to 4 years to allow more claimants access to the fund and to help alleviate the potential backlog of claims at the beginning of the Fund’s creation.

4. Coverage for Claimant Exposures on U.S. Flag Ships or While Working for U.S. Companies Abroad: This amendment broadens eligibility to include claims made by U.S. citizens exposed to asbestos while serving on any U.S. flagged or owned ship or exposed to asbestos while working for U.S. companies overseas.

5. Strengthening Enforcement of Contributions: This amendment strengthens the Administrator’s cause of action to enforce contributions by permitting the assessment of punitive damages for willful failure to pay.

6. Recoupment Authority for the Administrator: This amendment protects the funds available to pay claimants by permitting the Administrator to recover any financial hardship or inequity adjustment in future years if a company later becomes financially capable of paying its full allocation into the fund.

7. Criminal Penalties for Fraud or False Information: This amendment protects the integrity of the claims administration process by imposing criminal penalties for fraud and false statements made against the Fund.

8. Bankruptcy Certification: Requires the bankruptcy court to certify whether or not asbestos liabilities were the cause of the bankruptcy.

9. Congressional Oversight—Administrator Annual Reports: This amendment provides appropriate Congressional oversight by requiring the Administrator of the Asbestos Fund to submit an annual report on the functioning of the Fund to Congress.

Technical Amendments

10. Hatch Technical Amendment: Technical amendments to S. 1125.

Other Agreed Upon Amendments

11. Hatch Libby Amendment: Senator BAUCUS has agreed to this Amendment, which ensures that claimants from Libby, Montana will be compensated from this Fund and that their claims will be evaluated by the exceptions panel due to the unique nature of the asbestos there.

12. Hatch Asbestos Ban: This amendment prohibits the manufacture, distribution and importation of the consumer products to which asbestos is deliberately or knowingly added. The amendment also contains specific exemptions and authorizes the Administrator to hear and grant exemptions on a case by case basis.

13. Feinstein Second Degree to Hatch Asbestos Ban: This amendment adds certification requirements for the Government Use exemption, and authorizes the Administrator of the EPA to review the exemption for roofing cements and related products.

Medical Criteria Amendments

14. Hatch Medical Exceptions Panel Amendment: This panel will review claims which do not fit the criteria but may have an exceptional case to merit payment. Libby claims will automatically go through this panel.

15. Hatch Striking Product ID Amendment: (Leahy co-sponsor)—Drops requirements to identify particular asbestos product.

16. Hatch Latency Period Amendment: (Leahy co-sponsor)—Clarifies the 10-year latency period for all claims.

17. Hatch Medical Monitoring Amendment: Requires the administrator to notify qualifying claimants about medical monitoring options.

18. Hatch Doctor Evaluation Amendment: Requires physician to evaluate smoking and exposure history before making a diagnosis.