

SA 1069. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1070. Mr. SCHUMER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1071. Mr. ROCKEFELLER (for himself and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1072. Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1073. Mr. SMITH (for himself, Mr. FEINGOLD, and Ms. CANTWELL) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1074. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1075. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1076. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1077. Ms. STABENOW (for herself and Mr. LEVIN) proposed an amendment to the bill S. 1, supra.

SA 1078. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1079. Mr. LEVIN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1080. Mr. DEWINE (for himself and Mr. DURBIN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1081. Ms. LANDRIEU submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1082. Mr. CONRAD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1083. Mr. COLEMAN submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1084. Mr. VOINOVICH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1085. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1086. Ms. MURKOWSKI submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1087. Mr. GRASSLEY (for Mr. CRAIG) proposed an amendment to the bill S. 1, supra.

SA 1088. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1089. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1090. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1091. Mr. BAUCUS (for Ms. MIKULSKI) proposed an amendment to the bill S. 1, supra.

SA 1092. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, supra.

SA 1093. Mr. KYL proposed an amendment to amendment SA 1092 proposed by Mr.

GRASSLEY (for himself and Mr. BAUCUS) to the bill S. 1, supra.

TEXT OF AMENDMENTS

SA 1044. Mr. BAYH 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. ____ URBAN HEALTH PROVIDER ADJUSTMENT.

(a) **IN GENERAL.**—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to a hospital described in subsection (b) shall be made without regard to the DSH allotment limitation for the State determined under section 1923(f) of that Act (42 U.S.C. 1396r-4(f)).

(b) **HOSPITAL DESCRIBED.**—A hospital is described in this subsection if the hospital—

(1) is owned or operated by a State (as defined for purposes of title XIX of the Social Security Act), or by an instrumentality or a municipal governmental unit within a State (as so defined) as of January 1, 2003; and

(2) is located in Marion County, Indiana.

(c) **LIMITATION.**—The payment adjustment described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not exceed 175 percent of the costs of furnishing hospital services described in section 1923(g)(1)(A) of the Social Security Act (42 U.S.C. 1396r-4(g)(1)(A)).

SA 1045. Mr. CHAMBLISS 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. ____ DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) **DEMONSTRATION PROJECT.**—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), the amount of payment for a device of brachytherapy furnished under the demonstration project shall be equal to the hospital's charges for each device furnished, adjusted to cost.

(b) **SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.**—The Secretary shall create additional groups of covered OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate

groups for palladium-103 and iodine-125 devices.

(c) **DURATION.**—The Secretary shall conduct the demonstration project under this section for the 3-year period beginning on the date that is 90 days after the date of enactment of this Act.

(d) **REPORT.**—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project conducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) **WAIVER AUTHORITY.**—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.

(f) **FUNDING.**—

(1) **IN GENERAL.**—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration project under this section.

(2) **BUDGET NEUTRALITY.**—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration project under this section was not implemented.

SA 1046. Mr. CHAMBLISS 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. ____ DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) **DEMONSTRATION PROJECT.**—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) **DEFINITIONS.**—In this section:

(1) **SURGICAL FIRST ASSISTING SERVICES.**—The term "surgical first assisting services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) **CERTIFIED REGISTERED NURSE FIRST ASSISTANT.**—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) **PAYMENT RATES.**—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) for the same services if furnished by a physician.

(d) **DEMONSTRATION PROJECT SITES.**—The project established under this section shall be conducted in 5 States selected by the Secretary.

(e) **DURATION.**—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) **REPORT.**—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) **FUNDING.**—

(1) **IN GENERAL.**—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the project under this section.

(2) **BUDGET NEUTRALITY.**—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(i) **WAIVER AUTHORITY.**—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SA 1047. Mr. LEVIN 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 78, line 15, insert before the period the following: “and all succeeding years. Once such a determination is made with respect to an area, the Administrator shall ensure that a contract of the type entered into under the preceding sentence remains in effect for such area for each such succeeding year and beneficiaries receiving the standard prescription drug coverage under such a contract may elect to remain enrolled in such coverage under a such contract regardless of whether the access required under subsection (d)(1) is going to be provided in the area in the year”.

SA 1048. Mr. LEVIN 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 79, between line 22 and 23, insert the following:

“(F) **PERMANENT FALLBACK IN CERTAIN AREAS.**—

“(i) **IN GENERAL.**—Notwithstanding paragraph (1), in the case of an applicable area,

the Administrator shall enter into a contract under paragraph (1)(B) with respect to the area for each year after the year in which the area meets the definition of an applicable area. Eligible beneficiaries residing in such area may elect to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)) under such contract in a year regardless of whether the access required under subsection (d)(1) is going to be provided in the area in that year.

“(ii) **APPLICABLE AREA.**—For purposes of this subparagraph, the term ‘applicable area’ means an area—

“(I) that was designated under paragraph (1)(B) for a year;

“(II) in which the access required under subsection (d)(1) was met with respect to a year subsequent to the year described in subclause (I); and

“(III) that was designated under paragraph (1)(B) for a year subsequent to the year described in subclause (II).

SA 1049. Mr. LEVIN 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:

Beginning on page 39, strike line 23 through page 40, line 2, and insert the following:

“(E) **RESTRICTIONS ON REMOVING DRUGS FROM FORMULARY.**—An eligible entity may not remove a drug from the formulary under the plan—

“(i) during the 2-year contract for the plan; and

“(ii) unless the entity has provided appropriate notice to beneficiaries, physicians, and pharmacists that the drug will be removed at the beginning of the subsequent 2-year contract for the plan.

SA 1050. Mr. LEVIN 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 79, between line 22 and 23, insert the following:

“(F) **PERMANENT FALLBACK FOR CERTAIN BENEFICIARIES.**—

“(i) **IN GENERAL.**—Notwithstanding paragraph (1), the Administrator shall enter into a contract under paragraph (1)(B) for each area for each year. Applicable eligible beneficiaries residing in such area may elect to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)) under such contract in a year regardless of whether the access required under subsection (d)(1) is going to be provided in the area in that year. Other eligible beneficiaries residing in such area may elect to receive such coverage under such contract only if the area has been designated under paragraph (1)(B) for the year.

“(ii) **APPLICABLE ELIGIBLE BENEFICIARY.**—For purposes of this subparagraph, the term ‘applicable eligible beneficiary’ means an individual who—

“(I) is enrolled under this part;

“(II) was covered under a group health plan; and

“(III) involuntarily lost such coverage such that the beneficiary was eligible for a special open enrollment period under section 1860D-2(b)(3).

SA 1051. Mr. ENZI (for himself, Mrs. LINCOLN, Mr. PRYOR, and Ms. MURKOWSKI) 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 37, between lines 20 and 21, insert the following:

“(C) **CONVENIENT ACCESS TO PHARMACIES.**—In this section, the term ‘convenient access’ means access that is no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TriCare retail pharmacy program. Such rules shall include adequate emergency access for enrolled beneficiaries.

On page 48, between lines 4 and 5, insert the following:

“(4) **TYING OF CONTRACTS.**—No eligible entity with a contract under this part, or its agent, may require a pharmacy to participate in a medicare prescription drug plan as a condition of participating in nonmedicare programs or networks, or require a pharmacy to participate in a nonmedicare program or network as a condition of participating in a medicare prescription drug plan.

SA 1052. Mr. EDWARDS (for himself and Mr. HARKIN) 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, add the following:

TITLE —DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. 01. DIRECT-TO-CONSUMER ADVERTISING.

Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended by inserting at the end the following:

REGULATIONS.—

(1) **IN GENERAL.**—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) **CONTENTS.**—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including, if available, effectiveness in comparison to other drugs for substantially the same condition or conditions); and

(ii) information relating to side effects and contraindications;

(B) any advertisement present a fair balance, comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual presentations relating to side effects and contraindications, *provided that*, nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. 02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

“(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

“(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

“(A) the Secretary provides the person written notice of the violation; and

“(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

“(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

“(A) shall not exceed \$500,000 in the case of an individual and \$5,000,000 in the case of any other person; and

“(B) shall not exceed \$10,000,000 for all such violations adjudicated in a single proceeding.

“(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).”.

SEC. 03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. 04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rule-making; or

(2) as the Secretary determines to be necessary to protect public health and safety.

SA 1053. 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 to 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 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

“(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).”.

SA 1054. Mr. FEINGOLD 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 D of title I, add the following:

SEC. 133. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the “Office”).

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for medicare beneficiaries to use to obtain information on the medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and Medicare Advantage plans offering such benefits. The Office shall ensure that the toll-free telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and Medicare Advantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;

(B) have printer-friendly, downloadable fact sheets on the medicare coverage options and benefits;

(C) be easy to navigate, with large print and easily recognizable links; and

(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;

(B) formularies; and

(C) the scope of the benefits offered.

(4) Conducting outreach to medicare beneficiaries to inform the beneficiaries of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits administrators, ombudsmen, local benefits specialists, and advocacy groups to ensure that medicare beneficiaries are aware of the medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—

(1) ESTABLISHMENT.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, \$2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year.

SA 1055. Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr. DURBIN, Mr. KERRY, and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 1004 proposed by Mrs. HUTCHISON 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:

In lieu of the matter proposed to be added, add the following:

SEC. . REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(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” after the semicolon at the end;

(2) in subclause (VII)—

(A) by striking “on or after October 1, 2002” and inserting “during fiscal year 2003”; and

(B) by striking the period at the end and inserting a semicolon; and

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

“(VIII) during fiscal year 2004, ‘c’ is equal to 1.41; and

“(IX) on or after October 1, 2005, ‘c’ is equal to 1.47.”.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

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

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

At the end of subtitle B of title IV, 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”;

(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)(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 1056. Mr. SHELBY (for himself, Ms. STABENOW, Mr. SESSIONS, Mr. COCHRAN, Mr. LOTT, and Mrs. MURRAY) 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 IV, add the following:

SEC. ____ TREATMENT OF GRANDFATHERED LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—The last sentence of section 1886(d)(1)(B) is amended by inserting “, and the Secretary may not impose any special conditions on the operation, size, number of beds, or location of any hospital so classified for continued participation under this title or title XIX or for continued classification as a hospital described in clause (iv)” before the period at the end.

(b) TREATMENT OF PROPOSED REVISION.—The Secretary shall not adopt the proposed revision to section 412.22(f) of title 42, Code of Federal Regulations contained in 68 Federal Register 27154 (May 19, 2003) or any revision reaching the same or substantially the same result as such revision.

(c) EFFECTIVE DATE.—The amendment made by, and provisions of, this section shall apply to cost reporting periods ending on or after December 31, 2002.

SA 1057. Mrs. DOLE (for herself and Mr. EDWARDS) 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. ____ TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(b) BUDGET NEUTRAL.—The Secretary shall adjust the area wage index referred to in subsection (a) in a manner which assures that the appropriate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395(w)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

(c) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—Notwithstanding any other provision of law, effective beginning October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395(j)(o)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(d) APPLICATION.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, prereclassified hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This provision must be implemented in a budget neutral manner, using a methodology that maintains the current SNF and home health expenditure levels.

SA 1058. 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 appropriate place in title VI, insert the following:

SEC. ____ RESTORATION OF FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DEFINITIONS.—In this section:

(1) CLERICAL ERROR.—The term “clerical error” means the failure that occurred on April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to the Trust Fund.

(2) TRUST FUND.—The term “Trust Fund” means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(b) CORRECTION OF TRUST FUND HOLDINGS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, the holdings that would have been held by the Trust Fund if the clerical error had not occurred.

(2) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION.—Not later than 120 days after the date of enactment of this Act, there is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the

Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

SA 1059. Mr. HATCH 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 I, add the following:

SEC. ____ REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES.

(a) REVIEW.—

(1) IN GENERAL.—The Secretary shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

(2) SPECIFIC MATTERS REVIEWED.—In conducting the review under paragraph (1), the Secretary shall—

(A) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

(b) REPORT.—

(1) IN GENERAL.—Not later than the date that is 18 months after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a)(1), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

(2) CONTENTS.—The report submitted under paragraph (1) shall contain—

(A) a detailed description of the plans of the Secretary to implement the provisions of this Act in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

(B) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

SA 1060. Mr. BAUCUS (for Mrs. FEINSTEIN (for herself, Mr. NICKLES, Mr. CHAFEE, and Mr. GRAHAM of South Carolina) 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 title IV, insert:

Subtitle D—Part B Premium

SEC. ____ INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

“(h) INCREASE IN PREMIUM FOR HIGH-INCOME BENEFICIARIES.—

“(1) AMOUNT OF INCREASE.—

“(A) IN GENERAL.—Except as provided in paragraph (4), if the modified adjusted gross income of an individual for a taxable year

ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (2)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

“(B) APPLICABLE PERCENTAGE.—The term ‘applicable percentage’ means the percentage determined in accordance with the following tables:

“(i) INDIVIDUALS NOT FILING JOINT RETURNS.—

“If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than \$25,000	50 percent
More than \$25,000	100 percent.

“(ii) INDIVIDUALS FILING JOINT RETURNS.—

“If the modified adjusted gross income exceeds the threshold amount by:	The applicable percentage is:
Not more than \$50,000	50 percent
More than \$50,000	100 percent.

“(C) DEFINITION OF THRESHOLD AMOUNT.—For purposes of this subsection, the term ‘threshold amount’ means—

“(i) except as provided in clause (ii), \$75,000; and

“(ii) \$150,000 in the case of a taxpayer filing a joint return.

“(D) INFLATION ADJUSTMENT FOR THRESHOLD AMOUNT.—

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

“(I) such dollar amount, multiplied by

“(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding calendar year exceeds such average for the 12-month period ending with June 2005.

“(ii) JOINT RETURNS.—The dollar amount described in clause (ii) of subparagraph (C) for any calendar year after 2006 shall be increased to an amount equal to twice the amount in effect under clause (i) of subparagraph (C) (after application of this subparagraph).

“(iii) ROUNDING.—If any dollar amount after being increased under clause (i) is not a multiple of \$1,000, such dollar amount shall be rounded to the nearest multiple of \$1,000.

“(E) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term ‘modified adjusted gross income’ means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

“(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

“(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

“(F) JOINT RETURN.—For purposes of this subsection, the term ‘joint return’ has the meaning given such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

“(2) DETERMINATION OF MODIFIED ADJUSTED GROSS INCOME.—The Secretary shall make an initial determination of the amount of an individual’s modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

“(A) NOTICE.—Not later than September 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual’s actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary’s estimate of the individual’s modified adjusted gross income for the year. In providing such notice, the Secretary shall use the most recent poverty line available as of the date the notice is sent.

“(B) CALCULATION BASED ON INFORMATION PROVIDED BY BENEFICIARY.—If, during the 60-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with appropriate information (as determined by the Secretary) on the individual’s anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

“(C) CALCULATION BASED ON NOTICE AMOUNT IF NO INFORMATION IS PROVIDED BY THE BENEFICIARY OR IF THE SECRETARY DETERMINES THAT THE PROVIDED INFORMATION IS NOT APPROPRIATE.—The amount initially determined by the Secretary under this paragraph with respect to an individual shall be the amount included in the notice provided to the individual under subparagraph (A) if—

“(i) the individual does not provide the Secretary with information under subparagraph (B); or

“(ii) the Secretary determines that the information provided by the individual to the Secretary under such subparagraph is not appropriate.

“(3) ADJUSTMENTS.—

“(A) IN GENERAL.—If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual’s actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (2), the Secretary shall increase or decrease the amount of the individual’s monthly premium under this part (as the case may be) for months during the following calendar year by an amount equal to 1/2 of the difference between—

“(i) the total amount of all monthly premiums paid by the individual under this part during the previous calendar year; and

“(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual’s modified adjusted gross income initially determined under paragraph (2) were equal to the actual amount of the individual’s modified adjusted gross income determined under this paragraph.

“(B) INTEREST.—

“(i) INCREASE.—In the case of an individual for whom the amount initially determined by the Secretary under paragraph (2) is based on information provided by the individual under subparagraph (B) of such paragraph, if the Secretary determines under subparagraph (A) that the amount of the individual’s actual modified adjusted gross income for a taxable year is greater than the amount initially determined under paragraph (2), the Secretary shall increase the amount otherwise determined for the year under subparagraph (A) by an amount of interest equal to the sum of the amounts determined under

clause (ii) for each of the months described in such clause.

“(ii) COMPUTATION.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 (compounded daily) to any portion of the difference between the amount initially determined under paragraph (2) and the amount determined under subparagraph (A) for the period beginning on the first day of the month beginning after the individual provided information to the Secretary under subparagraph (B) of paragraph (2) and ending 30 days before the first month for which the individual’s monthly premium is increased under this paragraph.

“(iii) EXCEPTION.—Interest shall not be imposed under this subparagraph if the amount of the individual’s modified adjusted gross income provided by the individual under subparagraph (B) of paragraph (2) was not less than the individual’s modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for the taxable year involved.

“(C) STEPS TO RECOVER AMOUNTS DUE FROM PREVIOUSLY ENROLLED BENEFICIARIES.—In the case of an individual who is not enrolled under this part for any calendar year for which the individual’s monthly premium under this part for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual’s monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

“(D) DECEASED BENEFICIARY.—In the case of a deceased individual for whom the amount of the monthly premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual’s surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual’s estate) in an amount equal to the difference between—

“(i) the total amount by which the individual’s premium would have been decreased for all months during the year pursuant to subparagraph (A); and

“(ii) the amount (if any) by which the individual’s premium was decreased for months during the year pursuant to subparagraph (A).

“(4) WAIVER BY SECRETARY.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

“(5) TRANSFER TO PART B TRUST FUND.—

“(A) IN GENERAL.—The Secretary shall transfer amounts received pursuant to this subsection to the Federal Supplementary Medical Insurance Trust Fund.

“(B) DISREGARD.—In applying section 1844(a), amounts attributable to subparagraph (A) shall not be counted in determining the dollar amount of the premium per enrollee under paragraph (1)(A) or (1)(B) thereof.”

(b) CONFORMING AMENDMENTS.—(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by inserting “or subsection (h)” after “subsections (b) and (e)”;

(B) in subsection (a)(3) of section 1839(a), by inserting “or subsection (h)” after “subsection (e)”;

(C) in subsection (b), inserting “(and as increased under subsection (h))” after “subsection (a) or (e)”;

(D) in subsection (f), by striking “if an individual” and inserting the following: “if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))”.

(2) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting “or an individual determines that the estimate of modified adjusted gross income used in determining whether the individual is subject to an increase in the monthly premium under section 1839 pursuant to subsection (h) of such section (or in determining the amount of such increase) is too low and results in a portion of the premium not being deducted,” before “he may”.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

“(19) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

“(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Centers for Medicare & Medicaid Services return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

“(i) taxpayer identity information with respect to such taxpayer,

“(ii) the filing status of such taxpayer,

“(iii) the adjusted gross income of such taxpayer,

“(iv) the amounts excluded from such taxpayer’s gross income under sections 135 and 911,

“(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

“(vi) the amounts excluded from such taxpayer’s gross income by sections 931 and 933 to the extent such information is available.

“(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.”

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3)(A) of section 6103(p) of such Code is amended by striking “or (18)” each place it appears and inserting “(18), or (19)”.

(B) Paragraph (4) of section 6103(p) of such Code is amended by striking “or (16)” and inserting “(16), or (19)”.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 2006.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(19) of the Social Security Act (as added by subsection (c)) for taxable years beginning after December 31, 2002.

SA 1061. Mr. BAUCUS (for Mr. AKAKA (for himself and 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:

On page 633, after line 21, add the following:

(3) APPLICATION TO HAWAII.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as amended by paragraph (1), is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

“(7) TREATMENT OF HAWAII AS A LOW-DSH STATE.—The Secretary shall compute a DSH allotment for the State of Hawaii for each of fiscal years 2004 and 2005 in the same manner as DSH allotments are determined with respect to those States to which paragraph (5) applies (but without regard to the requirement under such paragraph that total expenditures under the State plan for disproportionate share hospital adjustments for any fiscal year exceeds 0).”

SA 1062. Mr. REID (for Mrs. BOXER) proposed an amendment to amendment SA 974 proposed by Mr. GRASSLEY (for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL) 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 the amendment add the following:

“SEC. ____ . 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 1063. 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 title IV, insert the following:

SEC. ____ . MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for

payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

SA 1064. Ms. SNOWE (for herself, Mr. ROCKEFELLER, and Mr. SMITH) 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. —. MEDICARE COVERAGE OF ALL ANTICANCER ORAL DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking “chemotherapeutic agent for a given indication,” and all that follows and inserting “agent for a medically accepted indication (as defined in subsection (t)(2)(B));”.

(b) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended by striking “therapeutic”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to drugs furnished during the period that begins on January 1, 2004 and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this subsection had never been enacted.

SA 1065. Mr. BINGAMAN (for himself, Mr. DOMENICI, Ms. MIKULSKI, and Mrs. LINCOLN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 120, between lines 16 and 17, insert the following:

“(I) UPDATE OF ASSET OR RESOURCE TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section that are made on or after January 1, 2009, such determinations shall be made (to the extent a State, as of such date, has not already eliminated the application of an asset or resource test under section 1905(p)(1)(C)) in accordance with the following:

“(i) SELF-DECLARATION OF VALUE.—

“(I) IN GENERAL.—A State shall permit an individual applying for such subsidies to de-

clare and certify by signature under penalty of perjury on the application form that the value of the individual’s assets or resources (or the combined value of the individual’s assets or resources and the assets or resources of the individual’s spouse), as determined under section 1613 for purposes of the supplemental security income program, does not exceed \$10,000 (\$20,000 in the case of the combined value of the individual’s assets or resources and the assets or resources of the individual’s spouse).

“(II) ANNUAL ADJUSTMENT.—Beginning on January 1, 2010, and for each subsequent year, the dollar amounts specified in subclause (I) for the preceding year shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

“(ii) METHODOLOGY FLEXIBILITY.—Nothing in clause (i) shall be construed as prohibiting a State in making eligibility determinations for premium and cost-sharing subsidies under this section from using asset or resource methodologies that are less restrictive than the methodologies used under 1613 for purposes of the supplemental security income program.

“(J) DEVELOPMENT OF MODEL DECLARATION FORM.—The Secretary shall—

“(i) develop a model, simplified application form for individuals to use in making a self-declaration of assets or resources in accordance with subparagraph (I)(i); and

“(ii) provide such form to States and, for purposes of outreach under section 1144, the Commissioner of Social Security.”.

SA 1066. Mr. BINGAMAN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 137, line 6, strike “Notwithstanding” and insert “Except as provided in paragraph (4) and notwithstanding”.

On page 138, line 2, strike “or ‘G’” and insert “‘G’, or a policy described in paragraph (4)”.

On page 138, line 17, insert “, who seeks to enroll with the same issuer who was the issuer of the policy described in clause (ii) of such subparagraph in which the individual was enrolled (unless such issuer does not offer at least one of the policies described in paragraph (4)),” after “section 1860D–2(b)(2)”.

On page 140, between lines 13 and 14, insert the following:

“(4) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Prescription Drug and Medicare Improvement Act of 2003, with respect to policies issued to individuals who are enrolled in a Medicare Prescription Drug plan under part D or under a contract under section 1860D–3(e), the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that shall be consistent with the following:

“(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

“(i) The policy should provide coverage for benefits other than prescription drugs similar to the coverage for benefits other than prescription drugs provided under a medicare supplemental policy which had a benefit

package classified as ‘H’ before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003.

“(ii) The policy should provide coverage for prescription drugs that—

“(I) compliments, but does not duplicate, the benefits available under part D; and

“(II) does not cover 100 percent of the deductible, copayments, coinsurance (including any cost-sharing applicable under the limitation on out-of-pocket expenditures), or any other cost-sharing applicable under part D.

“(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except that the reference to the benefit package classified as ‘H’ in clause (i) of such subparagraph is deemed to be a reference to the benefit package classified as ‘J’.

(b) REPORT.—The Secretary shall enter into an arrangement with the National Association of Insurance Commissioners (in this section referred to as the “NAIC”) under which, not later than 18 months after the date of enactment of this Act, the NAIC shall submit to Congress a report on the medicare supplemental policies described in section 1882(v)(4) of the Social Security Act, as added by subsection (a), that assesses the viability of the policies described in such section and, if viable, the details of those policies.

SA 1067. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, after line 18, add the following:

SEC. —. MEDICARE COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C.1395x) is amended—

(A) in subsection (s)(2)—

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

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

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

“(W) kidney disease education services (as defined in subsection (ww));” and

(B) by adding at the end the following new subsection:

“Kidney Disease Education Services

“(ww)(1) The term ‘kidney disease education services’ means educational services that are—

“(A) furnished to an individual with kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

“(B) furnished, upon the referral of the physician managing the individual’s kidney condition, by a qualified person (as defined in paragraph (2)); and

“(C) designed—

“(i) to provide comprehensive information regarding—

“(I) the management of comorbidities;

“(II) the prevention of uremic complications; and

“(III) each option for renal replacement therapy (including peritoneal dialysis, hemodialysis (including vascular access options), and transplantation); and

“(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy.

“(2) The term ‘qualified person’ means—
 “(A) a physician (as described in subsection (r)(1));
 “(B) an individual who—
 “(i) is—
 “(I) a registered nurse;
 “(II) a registered dietitian or nutrition professional (as defined in subsection (vv)(2));
 “(III) a clinical social worker (as defined in subsection (hh)(1));
 “(IV) a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)); or
 “(V) a transplant coordinator; and
 “(ii) meets such requirements related to experience and other qualifications that the Secretary finds necessary and appropriate for furnishing the services described in paragraph (1); or
 “(C) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—
 “(i) provide the services described in paragraph (1); and
 “(ii) meet the requirements of subparagraph (A) or (B).
 “(3) The Secretary shall develop the requirements under paragraph (2)(B)(ii) after consulting with physicians, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons.
 “(4) In promulgating regulations to carry out this subsection, the Secretary shall ensure that such regulations ensure that each beneficiary who is entitled to kidney disease education services under this title receives such services in a timely manner that ensures that the beneficiary receives the maximum benefit of those services.
 “(5) The Secretary shall monitor the implementation of this subsection to ensure that beneficiaries who are eligible for kidney disease education services receive such services in the manner described in paragraph (4).”
 (2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting “, (2)(W)”, after “(2)(S)”.
 (3) PAYMENT TO RENAL DIALYSIS FACILITIES.—Section 1881(b) of such Act (42 U.S.C. 1395rr(b)), as amended by section 433(b)(5), is further amended by adding at the end the following new paragraph:
 “(13) For purposes of paragraph (7), the single composite weighted formulas determined under such paragraph shall not take into account the amount of payment for kidney disease education services (as defined in section 1861(ww)). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848.”
 (4) ANNUAL REPORT TO CONGRESS.—Not later than April 1, 2004, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the number of medicare beneficiaries who are entitled to kidney disease education services (as defined in section 1861(ww) of the Social Security Act, as added by paragraph (1)) under title XVIII of such Act and who receive such services, together with such recommendations for legislative and administrative action as the Secretary determines to be appropriate to fulfill the legislative intent that resulted in the enactment of that subsection.
 (b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date that is 6 months after the date of enactment of this Act.

SA 1068. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:
 On page 510, after line 18, add the following:
SEC. ____ . MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.
 (a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—
 (1) in subparagraph (U), by striking “and” at the end;
 (2) in subparagraph (V)(iii), by adding “and” at the end; and
 (3) by adding at the end the following new subparagraph:
 “(W) diabetes screening tests and services (as defined in subsection (ww))”;
 (b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:
 “Diabetes Screening Tests and Services
 “(ww)(1) The term ‘diabetes screening tests’ means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—
 “(A) a fasting plasma glucose test; and
 “(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.
 “(2) For purposes of paragraph (1), the term ‘individual at risk for diabetes’ means an individual who has any, a combination of, or all of the following risk factors for diabetes:
 “(A) A family history of diabetes.
 “(B) Overweight defined as a body mass index greater than or equal to 25 kg/m².
 “(C) Habitual physical inactivity.
 “(D) Belonging to a high-risk ethnic or racial group.
 “(E) Previous identification of an elevated impaired fasting glucose.
 “(F) Identification of impaired glucose tolerance.
 “(G) Hypertension.
 “(H) Dyslipidemia.
 “(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.
 “(J) Polycystic ovary syndrome.
 “(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.”
 (c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—
 (1) in subparagraph (H), by striking “and” at the end;
 (2) in subparagraph (I), by striking the semicolon at the end and inserting “, and”;
 (3) by adding at the end the following new subparagraph:
 “(J) in the case of a diabetes screening test or service (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(3).”
 (d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

SA 1069. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:
 On page 499, after line 20, insert the following:
SEC. ____ . ELIMINATION OF COST-SHARING FOR BONE MASS MEASUREMENTS.
 (a) ELIMINATION OF COINSURANCE.—
 (1) IN GENERAL.—Section 1833(a)(1)(N) of the Social Security Act (42 U.S.C. 1395f(a)(1)(N)) is amended—
 (A) by inserting “other than bone mass measurement described in section 1861(s)(15)” after “(as defined in section 1848(j)(3))”; and
 (B) by adding after the comma at the end the following: “and in the case of such services consisting of such a bone mass measurement, the amounts paid shall be 100 percent of such payment basis.”
 (2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after “1861(s)(10)(A)” the following: “, with respect to bone mass measurement (as defined in section 1861(rr))”.
 (b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395f(b)), as amended by section 432(b), is further amended—
 (1) by striking “and” before “(5)”; and
 (2) by inserting before the period at the end the following: “, and (6) such deductible shall not apply with respect to bone mass measurement (as defined in section 1861(rr))”.
 (c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2004.
SA 1070. Mr. SCHUMER 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 120, strike lines 3 through 16, and insert the following:
 “(H) NONAPPLICATION TO DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual who is a dual eligible individual—
 “(i) the subsidies provided under this section shall not apply; and
 “(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with the State medicare program under title XIX.
 On page 122, line 1, strike “and territorial residents”.
 Beginning on page 149, strike line 22 and all that follows through page 152, line 3, and insert the following:
 “(e) DEFINITIONS.—For purposes of this section, the”
 On page 152, strike lines 8 through 11, and insert the following:
 (2) EXEMPTION FROM FUNDING LIMITATION FOR THE COMMONWEALTH OF PUERTO RICO AND THE TERRITORIES.—
 (A) IN GENERAL.—Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:
 “(3) CERTAIN PAYMENTS DISREGARDED.—The limitations under subsection (f) and the previous provisions of this subsection shall be

applied without regard to any payments made for medical assistance for covered drugs (as defined in section 1860D(a)(2)) under title XIX for dual eligible individuals (as defined in section 1860D-19(a)(4)(E) or for any payments made in carrying out section 1935.”.

(B) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

SA 1071. Mr. ROCKEFELLER (for himself and Mr. SMITH) 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 ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking “prescribed for use as an anticancer chemotherapeutic agent” and all that follows and inserting “prescribed for use as—

“(i) an antineoplastic agent for a medically accepted anticancer indication (as defined in subsection (t)(2)(B)), excluding (except as provided in subparagraph (T)) drugs for chemotherapy-induced nausea; or

“(ii) an oral alternative to IV-administered medications, but only if the Secretary determines such coverage does not result, as estimated by the Secretary, in expenditures made under this title during any 5-year period that are greater than the expenditures that would have been made under this title during such period if such coverage was not provided.”.

(b) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended to read as follows:

“(iv) oral drugs described in section 1861(s)(2)(Q); and”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply only with respect to drugs furnished during the period that begins on or after the date that is 90 days after the date of the enactment of this Act and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this section had never been enacted.

SA 1072. Mr. ROCKEFELLER 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 ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS; PUBLIC DISCLOSURE OF MARKET-BASED DRUG PRICING INFORMATION.

(a) MEDICARE COVERAGE OF ALL ANTINEOPLASTIC AND CERTAIN OTHER DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2)(Q) (42 U.S.C. 1395x(s)(2)(Q)) is amended by striking “prescribed for use as an anticancer chemotherapeutic agent” and all that follows and inserting “prescribed for use as—

“(i) an antineoplastic agent for a medically accepted anticancer indication (as defined in subsection (t)(2)(B)), excluding (except as provided in subparagraph (T)) drugs for chemotherapy-induced nausea; or

“(ii) an oral alternative to IV-administered medications, but only if the Secretary determines such coverage does not result, as estimated by the Secretary, in expenditures made under this title during any 5-year period that are greater than the expenditures that would have been made under this title during such period if such coverage was not provided.”.

(2) CONFORMING AMENDMENT.—Section 1834(j)(5)(F)(iv) (42 U.S.C. 1395m(j)(5)(F)(iv)) is amended to read as follows:

“(iv) oral drugs described in section 1861(s)(2)(Q); and”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply only with respect to drugs furnished during the period that begins on or after the date that is 90 days after the date of the enactment of this Act and ends on January 1, 2006. After January 1, 2006, the Social Security Act shall be applied and administered as if the amendments made by this subsection had never been enacted.

(b) PUBLIC DISCLOSURE OF MARKET-BASED DRUG PRICING INFORMATION.—

(1) IN GENERAL.—Section 1927(b)(3)(D) (42 U.S.C. 1396r-8(b)(3)(D)) is amended to read as follows:

“(D) PUBLIC AVAILABILITY OF INFORMATION.—

“(i) TIMELY AVAILABILITY OF INFORMATION.—Notwithstanding any other provision of law, with respect to a manufacturer with an agreement in effect under this section, not later than 30 days after the date the Secretary receives from such manufacturer the information required to be reported under this paragraph (or verifies such information with a wholesaler), the Secretary shall make the information described in clause (ii), including the identity of the manufacturer to which the information applies, publicly available through the Internet or other means of communication.

“(ii) INFORMATION DESCRIBED.—The information described in this clause is the following:

“(I) AVERAGE MANUFACTURER’S PRICE.—The average manufacturer price (as defined in subsection (k)(1)) for each of the manufacturer’s covered outpatient drugs.

“(II) BEST PRICE.—With respect to single source drugs and innovator multiple source drugs, the manufacturer’s best price (as defined in subsection (c)(1)(C)) for each of the manufacturer’s covered outpatient drugs.

“(III) BASE AVERAGE MANUFACTURER PRICE AND INITIAL AVERAGE MANUFACTURER PRICE FOR NEWLY MARKETED DRUGS USED TO DETERMINE AN ADDITIONAL REBATE FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—The average manufacturer price described in subparagraphs (A)(ii)(II) (without regard to the percentage increase determined under that subparagraph) and (B) of subsection (c)(2) for each dosage form and strength of a single source drug or an innovator multiple source drug used to determine, with respect to a rebate period, an additional rebate for such dosage form and strength for such a drug.

“(iii) NONDISCLOSURE OF CERTAIN INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers (or verified with wholesalers) under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A) may not be disclosed except—

“(I) as the Secretary determines to be necessary to carry out this section;

“(II) to permit the Comptroller General to review the information provided; or

“(III) to permit the Director of the Congressional Budget Office to review the information provided.

“(iv) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed as affecting any requirement applicable to the Secretary of Veterans Affairs regarding the confidentiality of information required to be disclosed to the Secretary of Veterans Affairs by a manufacturer under section 8126 of title 38, United States Code.”.

(2) EFFECTIVE DATE; IMPLEMENTATION.—

(A) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect upon the date of enactment of this Act and apply to the most recent reported price information under section 1927(b)(3) of the Social Security Act (42 U.S.C. 1396r-8(b)(3)) as of such date, and all such information reported under such section after such date.

(B) ADDITIONAL PERIOD FOR IMPLEMENTATION.—Notwithstanding the 30-day requirement for the public availability of market-based drug pricing information under section 1927(b)(3)(D)(i) of the Social Security Act (42 U.S.C. 1396r-8(b)(3)(D)(i)), with respect to the initial public availability of such information, the Secretary of Health and Human Services shall have up to 90 days from the date of the enactment of this Act in which to make such information so available.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out section 1927(b)(3)(D) of the Social Security Act (42 U.S.C. 1396r-8(b)(3)(D)), as amended by this subsection, such sums as may be necessary to carry out such section. Amounts appropriated pursuant to this subsection shall be in addition to amounts otherwise appropriated to carry out title XIX of such Act (42 U.S.C. 1396 et seq.).

SA 1073. Mr. SMITH (for himself, Mr. FEINGOLD, and Ms. CANTWELL) 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:

On page 379, strike lines 9 through 13, and insert:

“(A) IN GENERAL.—The term ‘specialized Medicare+Choice plans for special needs beneficiaries’ means a Medicare+Choice plan that—

“(i) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or

“(ii) to the extent provided in regulations prescribed by the Secretary, disproportionately serves such special needs beneficiaries, frail elderly medicare beneficiaries, or both.

SA 1074. Mr. COLEMAN 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 IV, add the following:

SEC. —. IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

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

(A) in the third sentence of subsection (a) by inserting “consistent with subsection (j)” after “the Secretary shall ensure”; and

(B) by adding at the end the following new subsection:

“(j) NATIONAL COVERAGE DETERMINATION PROCESS.—

“(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

“(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

“(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

“(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

“(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

“(B) provide a 30-day period for public comment on such draft;

“(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

“(D) include in such final decision summaries of the public comments received and responses thereto;

“(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

“(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C).

“(3) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term ‘national coverage determination’ has the meaning given such term in section 1869(f)(1)(B).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

SA 1075. Ms. STABENOW (for herself and Mr. LEVIN) 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 676, after line 22, add the following:

SEC. ____ EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking “until December 31, 2002”, and

(2) by striking “Kent Community Hospital Complex in Michigan or.”

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SA 1076. Ms. STABENOW (for herself and Mr. LEVIN) 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 438, between lines 10 and 11, insert the following:

SEC. ____ COMPREHENSIVE CANCER CENTERS.

(a) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by striking “or” at the end of subclause (III);

(B) by striking the semicolon at the end of subclause (IV) and inserting “, or”; and

(C) by inserting after subclause (IV) the following:

“(IV) a hospital that is a nonprofit corporation, the sole member of which was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that specifies in its articles of incorporation that at least 50 percent of its total discharges must have a principal finding of neoplastic disease, as defined in subparagraph (E), and that is a freestanding facility licensed for less than 131 acute care beds;”; and

(2) in subparagraph (E), by striking “(II) and (III)” and inserting “(II), (III), and (IV)”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning after the date of enactment of this Act.

SA 1077. Ms. STABENOW (for herself and Mr. LEVIN) 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 438, between lines 10 and 11, insert the following:

SEC. ____ REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting “subject to subparagraph (I),” after “October 1, 1997;”;

(2) in subparagraph (H)(i), by inserting “and subject to subparagraph (I),” after “subparagraphs (F) and (G).”; and

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

“(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

“(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

“(I) IN GENERAL.—If a hospital’s resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2003, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

“(II) REFERENCE PERIODS DEFINED.—In this clause, the term ‘reference periods’ means, for a hospital, the 3 most recent consecutive

cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2001.

“(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

“(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2002.

“(i) REDISTRIBUTION.—

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

“(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2003, or before the date of the hospital’s application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2004.

“(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

“(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

“(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

“(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

“(iii) RESIDENT LEVEL AND LIMIT DEFINED.—

“(I) RESIDENT LEVEL.—The term ‘resident level’ means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

“(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital,

the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.”.

(b) NO APPLICATION OF INCREASE TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: “The provisions of subsection (h)(4)(I) (determined without regard to clause (ii) thereof) shall apply with respect to the first sentence of this clause in the same manner as such provisions apply with respect to subparagraph (F) of such subsection.”.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary of Health and Human Services shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii) of the Social Security Act (as added by subsection (a)).

SA 1076. Mr. LEVIN 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 IV, add the following:

SEC. ____ REVISION OF ALTERNATIVE GUIDELINES FOR GEOGRAPHIC RECLASSIFICATION OF CERTAIN DISPROPORTIONATELY LARGE HOSPITALS.

Section 4409(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) is amended—

(1) in paragraph (1)—
(A) by inserting “(A)” after “(1)”;
(B) by adding “or” after the semicolon at the end; and

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

“(B) beginning with fiscal year 2003, the hospital is the only hospital located in such an Area”;

(2) in paragraph (2), by inserting “in the case of a hospital described in paragraph (1)(A),” before “not less than 40 percent”;

(3) in paragraph (3), by inserting “for fiscal years before 2003,” before “the hospital submitted an application”.

SA 1079. Mr. LEVIN 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 IV, add the following:

SEC. ____ RECLASSIFICATION OF CERTAIN RURAL COUNTIES FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal years 2003, 2004, and 2005, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), a hospital located in a rural county in a State that is adjacent to 1 or more urban areas is deemed to be located in the urban metropolitan statistical area from which the greatest number of hospital employees commute, if—

(1) the rural county is surrounded by urban metropolitan statistical areas; and

(2) the hospital would be reclassified as being located in an adjacent urban metropolitan statistical area for purposes of determining the wage index and the standardized amount applicable to the hospital but for a requirement that the hospital have a wage index that is 106 percent of its applicable rural wage index.

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

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary of Health and Human Services 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 of Health and Human Services 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 1080. Mr. DEWINE (for himself and Mr. DURBIN) 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 to 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. ____ COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) COMPREHENSIVE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended by striking “, to an individual who receives” and all that follows before the semicolon at the end and inserting “to an individual who has received an organ transplant”.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(b) PROVISION OF APPROPRIATE COVERAGE OF IMMUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PROGRAM FOR ORGAN TRANSPLANT RECIPIENTS.—

(1) CONTINUED ENTITLEMENT TO IMMUNOSUPPRESSIVE DRUGS.—

(A) KIDNEY TRANSPLANT RECIPIENTS.—Section 226A(b)(2) (42 U.S.C. 426-1(b)(2)) is amended by inserting “(except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))” after “shall end”.

(B) OTHER TRANSPLANT RECIPIENTS.—The flush matter following paragraph (2)(C)(ii)(II)

of section 226(b) (42 U.S.C. 426(b)) is amended by striking “of this subsection)” and inserting “of this subsection and except for coverage of immunosuppressive drugs under section 1861(s)(2)(J))”.

(C) APPLICATION.—Section 1836 (42 U.S.C. 1395o) is amended—

(i) by striking “Every individual who” and inserting “(a) IN GENERAL.—Every individual who”; and

(ii) by adding at the end the following new subsection:

“(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

“(1) IN GENERAL.—In the case of an individual whose eligibility for benefits under this title has ended except for the coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2), the following rules shall apply:

“(A) The individual shall be deemed to be enrolled under this part for purposes of receiving coverage of such drugs.

“(B) The individual shall be responsible for the full amount of the premium under section 1839 in order to receive such coverage.

“(C) The provision of such drugs shall be subject to the application of—

“(i) the deductible under section 1833(b); and

“(ii) the coinsurance amount applicable for such drugs (as determined under this part).

“(D) If the individual is an inpatient of a hospital or other entity, the individual is entitled to receive coverage of such drugs under this part.

“(2) ESTABLISHMENT OF PROCEDURES IN ORDER TO IMPLEMENT COVERAGE.—The Secretary shall establish procedures for—

“(A) identifying beneficiaries that are entitled to coverage of immunosuppressive drugs by reason of section 226(b) or 226A(b)(2); and

“(B) distinguishing such beneficiaries from beneficiaries that are enrolled under this part for the complete package of benefits under this part.”.

(D) TECHNICAL AMENDMENT.—Subsection (c) of section 226A (42 U.S.C. 426-1), as added by section 201(a)(3)(D)(ii) of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296; 108 Stat. 1497), is redesignated as subsection (d).

(2) EXTENSION OF SECONDARY PAYER REQUIREMENTS FOR ESRD BENEFICIARIES.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: “With regard to immunosuppressive drugs furnished on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, this subparagraph shall be applied without regard to any time limitation.”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(c) PLANS REQUIRED TO MAINTAIN COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) APPLICATION TO CERTAIN HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following:

“SEC. 2707. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

“A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such

requirement shall be deemed to be incorporated into this section.”.

(B) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting “(other than section 2707)” after “requirements of such subparts”.

(2) APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

“SEC. 714. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

“A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan or issuer on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.”.

(B) CONFORMING AMENDMENTS.—

(i) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711 and 714”.

(ii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

“Sec. 714. Coverage of immunosuppressive drugs.”.

(3) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(A) in the table of sections, by inserting after the item relating to section 9812 the following new item:

“Sec. 9813. Coverage of immunosuppressive drugs.”;

and

(B) by inserting after section 9812 the following:

“SEC. 9813. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.

“A group health plan shall provide coverage of immunosuppressive drugs that is at least as comprehensive as the coverage provided by such plan on the day before the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, and such requirement shall be deemed to be incorporated into this section.”.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2004.

SA 1081. Ms. LANDRIEU 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 476, between lines 5 and 6, insert the following:

(10) EXEMPTION FOR CERTAIN INHALATION DRUGS AND BIOLOGICALS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) (7) and (9), is amended by adding at the end the following new paragraph:

“(10)(A) Notwithstanding the preceding provisions of this subsection, in the case of

existing inhalation drugs and biologicals furnished on or after January 1, 2004, and before January 1, 2011, the payment rate for such drugs and biologicals shall be 95 percent of the average wholesale price (as in effect on June 30, 2003).

“(B) During the period described in subparagraph (A), the Secretary may not make any increased or separate payments under paragraph (8) with respect to existing inhalation drugs and biologicals.

“(C) For purposes of this paragraph, the term ‘existing inhalation drugs and biologicals’ means inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) that are first available for payment under this part on or before June 30, 2003.”.

SA 1082. Mr. CONRAD 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. . ACCELERATING THE RATE OF REDUCTION OF BENEFICIARY COPAYMENT LIABILITY UNDER THE MEDICARE HOSPITAL OUTPATIENT DEPARTMENT PROSPECTIVE PAYMENT SYSTEM.

Section 1833(t)(8)(C)(ii) (42 U.S.C. 1395l(t)(8)(C)(ii)) is amended—

(1) in subclause (V), by striking “and thereafter” and inserting “through 2008”; and

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

“(VI) For procedures performed in 2009, 36 percent.

“(VII) For procedures performed in 2010 and 2011, 34 percent.

“(VIII) For procedures performed in 2012, 32 percent.

“(IX) For procedures performed in 2013 and thereafter, 30 percent.”.

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)(i) 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 1083. Mr. COLEMAN 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 IV, add the following:

SEC. . TREATMENT OF CERTAIN ENTITIES FOR PURPOSES OF PAYMENTS UNDER THE MEDICARE PROGRAM.

(a) PAYMENTS TO HOSPITALS.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of making payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C.

1395(d)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Stearns County, Minnesota, such county is deemed to be located in the Minneapolis-St. Paul, Minnesota-Wisconsin, Metropolitan Statistical Area.

(b) BUDGET NEUTRALITY.—The Secretary shall adjust the area wage index referred to in subsection (a) in a manner which assures that the appropriate payments made under section 1886(d) of the Social Security Act (42 U.S.C., 1395(w)(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SA 1084. Mr. VOINOVICH 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 152, between lines 7 and 8, and insert the following:

“(g) STATE OPTION TO PAY MEDICARE PART D PRICE FOR COVERED OUTPATIENT DRUGS FOR DUAL ELIGIBLE INDIVIDUALS.—Notwithstanding any provision of title XVIII, or section 1927(c)(1)(C)(i), with respect to a State that provides medical assistance for a covered drug (as such term is defined in section 1860D(a)(2)) for a dual eligible individual enrolled under the State plan under this title (or under a waiver of such plan) that is also a covered outpatient drug (as defined for purposes of in section 1927) included on the State formulary established under section 1927, if the price the State would pay for the drug under this title exceeds the price that an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan would pay for the drug under title XVIII, the State may elect to pay the price that applies under title XVIII. An election by a State under the preceding sentence shall have no effect on the terms of a rebate agreement entered into under section 1927 which would otherwise apply to the provision of medical assistance for the covered outpatient drug.”.

SA 1085. Mr. SPECTER 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. ____ SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the

program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services under Medicare;

(6) the SGR system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between growth in Medicare beneficiary health care costs and our Nation's GDP, and a requirement for immediate recoupment of the difference;

(7) both administrative and legislative action are needed to return stability to the physician payment system;

(8) using the discretion given to it by Medicare law, CMS has included expenditures for prescription drugs and biologicals administered incident to physicians' services under the annual spending targets without making appropriate adjustments to the targets to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(9) between 1996 and 2002, annual Medicare spending on these drugs grew from \$1,800,000,000 to \$6,200,000,000, or from \$55 per beneficiary to an estimated \$187 per beneficiary;

(10) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards of care that encourage their use, are within the control of physicians; and

(11) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered incident to physician services from the sustainable growth rate (SGR) system;

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the SGR system, the conferees on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the variance and creating “tolerance” corridors for variations around the update target trend.

SA 1086. Ms. MURKOWSKI 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 37, strike lines 4 and 5 and insert “reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.”.

On page 165, strike lines 4 and 5 and insert “into account reasonable distances to pharmacy services in urban and rural areas and access to pharmacy services of the Indian Health Service and Indian tribes and tribal organizations.”.

SA 1087. Mr. GRASSLEY (for Mr. CRAIG) 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 II, add the following:

SEC. ____ ESTABLISHMENT OF MEDICAREADVANTAGE 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 MedicareAdvantage 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 MedicareAdvantage 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 preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

“(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

“(5) ASSURING ACCESS TO SERVICES IN 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 1088. Mr. BAUCUS (for 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:

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:

“(ii) 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 1089. Mr. BAUCUS (for 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:

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:

“(ii) 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 1090. Mr. BAUCUS (for 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:

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 1091. Mr. BAUCUS (for 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:

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 1092. Mr. GRASSLEY (for himself and Mr. BAUCUS) 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 C of title II, add the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

“(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

“(1) ANNUAL DETERMINATION AND DESIGNATION.—

“(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D-11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

“(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region de-

scribed in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

“(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

“(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

“(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

“(iii) Whether the Secretary expects that Medicare Advantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

“(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

“(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

“(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

“(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

“(3) SUBMISSION OF BIDS.—

“(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in the plan that resides in the service area of the plan for a month.

“(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

“(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

“(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

“(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

“(5) FUNDING LIMITATION.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period or year, as applicable, may not exceed the applicable amount (as defined in clause (ii)).

“(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term ‘applicable amount’ means—

“(I) for the period beginning on January 1, 2009, and ending on September 30, 2013, the total amount that would have been expended under this title during the period if this subsection had not been enacted plus \$6,000,000,000; and

“(II) for fiscal year 2014 and any subsequent fiscal year, the total amount that would have been expended under this title during the year if this subsection had not been enacted.

“(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

“(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

“(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

“(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

“(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

“(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

“(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

“(A) a detailed description of—

“(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(iii) amounts remaining within the funding limitation specified in paragraph (5); and

“(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to beneficiaries enrolled in a Medicare Advantage preferred provider plan in a highly competitive region;

“(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.”

(b) CONFORMING AMENDMENT.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) ESTABLISHMENT.—

(1) REVIEW AND REPORT ON RESULTS OF EXISTING DEMONSTRATIONS.—

(A) REVIEW.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) REPORT.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) PROJECTS.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) ENHANCED BENEFITS OR SERVICES.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) PROJECT SITES AND DURATION.—

(1) IN GENERAL.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that the region or regions are designated as such a highly competitive region.

(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) 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.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) FUNDING.—

(1) IN GENERAL.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) LIMITATION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus \$6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program

under parts A and B of such title during the year if the projects had not been conducted.

(3) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

SA 1093. Mr. KYL proposed an amendment to amendment SA 1092 proposed by Mr. GRASSLEY (for himself and Mr. BAUCUS) 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:

In lieu of the matter proposed to be inserted, insert the following:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—Section 1858 (as added by section 211(b)) is amended by adding at the end the following new subsection:

“(i) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

“(1) ANNUAL DETERMINATION AND DESIGNATION.—

“(A) IN 2008.—In 2008, prior to the date on which the Secretary expects to publish the risk adjusters under section 1860D–11, the Secretary shall designate a limited number (but in no case fewer than 1) of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions.

“(B) SUBSEQUENT YEARS.—For each year (beginning with 2009) the Secretary may designate a limited number of preferred provider regions (other than the region described in subsection (a)(2)(C)(ii)) as highly competitive regions in addition to any region designated as a highly competitive region under subparagraph (A).

“(C) CONSIDERATIONS.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

“(i) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

“(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

“(iii) Whether the Secretary expects that MedicareAdvantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

“(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

In considering the matters described in clauses (i) through (iv), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

“(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region under subparagraph (A) or (B) of paragraph (1)—

“(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmarks for preferred provider regions; and

“(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to paragraph (5)(B)(ii).

“(3) SUBMISSION OF BIDS.—

“(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1854(a)(2)(A)(i), the plan bid for a highly competitive region shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of only the benefits described in section 1852(a)(1)(A) to an individual enrolled in

the plan that resides in the service area of the plan for a month.

“(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as permitting a preferred provider organization plan not to provide coverage for the benefits described in section 1852(a)(1)(C).

“(4) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE AREAS.—With respect to highly competitive regions, the following rules shall apply:

“(A) IN GENERAL.—Notwithstanding subsection (c), of the plans described in subsection (d)(1)(E), the Secretary shall substitute the second lowest bid for the benchmark applicable under subsection (c)(4).

“(B) IF THERE ARE FEWER THAN THREE BIDS.—Notwithstanding subsection (c), if there are fewer than 3 bids in a highly competitive region for a year, the Secretary shall substitute the lowest bid for the benchmark applicable under subsection (c)(4).

“(5) FUNDING LIMITATION.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—The total amount expended as a result of the application of this subsection during the period beginning on January 1, 2009, and ending on September 30, 2013, may not exceed the applicable amount (as defined in clause (ii)).

“(ii) APPLICABLE AMOUNT DEFINED.—In this paragraph, the term ‘applicable amount’ means the total amount that would have been expended under this title during the period described in clause (i) if this subsection had not been enacted plus \$6,000,000,000.

“(B) APPLICATION OF LIMITATION.—If the Secretary determines that the application of this subsection will cause expenditures to exceed the applicable amount, the Secretary shall—

“(i) take appropriate steps to stay within the applicable amount, including through providing limitations on enrollment; or

“(ii) rescind the designation under subparagraph (A) or (B) of paragraph (1) of 1 or more preferred provider regions as highly competitive regions.

“(C) TRANSITION.—If the Secretary rescinds a designation under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(ii) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition from the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

“(D) APPLICATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in subparagraph (A)(ii)(II) begins, the Secretary may designate appropriate regions under such paragraph.

“(6) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).

“(7) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

“(A) a detailed description of—

“(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(ii) the projections of the total amount that will be expended as a result of the appli-

cation of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(iii) amounts remaining within the funding limitation specified in paragraph (5); and

“(iv) the steps that the Secretary will take under clauses (i) and (ii) of paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the applicable amount described in paragraph (5)(A); and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under clauses (i), (ii), (iii), and (iv) of subparagraph (A) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(8) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the designation of highly competitive regions under this subsection and the application of the payment system under this subsection within such regions. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to beneficiaries enrolled in a MedicareAdvantage preferred provider plan in a highly competitive region;

“(ii) the satisfaction of beneficiaries with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the benchmark system applicable under the other provisions of this section and the payment system applicable in highly competitive regions under this subsection; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.”

(b) CONFORMING AMENDMENT.—Section 1858(c)(3)(A)(i) (as added by section 211(b)) is amended to read as follows:

“(i) Whether each preferred provider region has been designated as a highly competitive region under subparagraph (A) or (B) of subsection (i)(1) and the benchmark amount for any preferred provider region (as calculated under paragraph (2)(A)) for the year that has not been designated as a highly competitive region.”

SEC. 232. FEE-FOR-SERVICE MODERNIZATION PROJECTS.

(a) ESTABLISHMENT.—

(1) REVIEW AND REPORT ON RESULTS OF EXISTING DEMONSTRATIONS.—

(A) REVIEW.—The Secretary shall conduct an empirical review of the results of the demonstrations under sections 442, 443, and 444.

(B) REPORT.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the empirical review conducted under subparagraph (A) which shall include estimates of the total costs of the demonstrations, including expenditures as a result of the provision of services provided to beneficiaries under the demonstrations that are incidental to the services provided under the demonstrations, and all other expenditures under title XVIII of the Social Security Act. The report shall also include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such estimates are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(2) PROJECTS.—Beginning in 2009, the Secretary, based on the empirical review conducted under paragraph (1), shall establish

projects under which medicare beneficiaries receiving benefits under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act are provided with coverage of enhanced benefits or services under such program. The purpose of such projects is to evaluate whether the provision of such enhanced benefits or services to such beneficiaries—

(A) improves the quality of care provided to such beneficiaries under the medicare program;

(B) improves the health care delivery system under the medicare program; and

(C) results in reduced expenditures under the medicare program.

(2) ENHANCED BENEFITS OR SERVICES.—For purposes of this section, enhanced benefits or services shall include—

(A) preventive services not otherwise covered under title XVIII of the Social Security Act;

(B) chronic care coordination services;

(C) disease management services; or

(D) other benefits or services that the Secretary determines will improve preventive health care for medicare beneficiaries, result in improved chronic disease management, and management of complex, life-threatening, or high-cost conditions and are consistent with the goals described in subparagraphs (A), (B), and (C) of paragraph (1).

(b) PROJECT SITES AND DURATION.—

(1) IN GENERAL.—Subject to subsection (e)(2), the projects under this section shall be conducted—

(A) in a region or regions that are comparable (as determined by the Secretary) to the region or regions that are designated as a highly competitive region under subparagraph (A) or (B) of section 1858(i)(1) of the Social Security Act, as added by section 231 of this Act; and

(B) during the years that the region or regions are designated as such a highly competitive region.

(2) RULE OF CONSTRUCTION.—For purposes of paragraph (1), a comparable region does not necessarily mean the identical region.

(c) 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.) only to the extent and for such period as the Secretary determines is necessary to provide for enhanced benefits or services consistent with the projects under this section.

(d) BIENNIAL GAO REPORTS.—Not later than January 1, 2011, and biennially thereafter for as long as the projects under this section are being conducted, the Comptroller General of the United States shall submit to the Secretary and Congress a report that evaluates the projects. Each report shall include—

(1) an evaluation of—

(A) the quality of care provided to beneficiaries receiving benefits or services under the projects;

(B) the satisfaction of beneficiaries receiving benefits or services under the projects;

(C) the costs to the medicare program under the projects; and

(D) any improvements in the delivery of health care services under the projects; and

(2) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

(e) FUNDING.—

(1) IN GENERAL.—Payments for the costs of carrying out the projects under this section shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), as determined appropriate by the Secretary.

(2) LIMITATION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the period or year, as applicable, may not exceed—

(A) for the period beginning on January 1, 2009, and ending on September 30, 2013, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus \$6,000,000,000; and

(B) for fiscal year 2014 and any subsequent fiscal year, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of such title during the year if the projects had not been conducted.

(3) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION IS NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(I) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the previous year compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(II) the projections of the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the year in which the report is submitted compared to the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(III) amounts remaining within the funding limitation specified in paragraph (2); and

(IV) how the Secretary will change the scope, site, and duration of the projects in subsequent years in order to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated; and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the descriptions under subclauses (I), (II), (III), and (IV) of clause (i) are reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

(4) APPLICATION OF LIMITATION.—If the Secretary determines that the projects under this section will cause the limitations described in subparagraphs (A) and (B) of paragraph (2) to be violated, the Secretary shall take appropriate steps to reduce spending under the projects, including through reducing the scope, site, and duration of the projects.

(5) AUTHORITY.—Beginning in 2014, the Secretary shall make necessary spending adjustments (including pro rata reductions in payments to health care providers under the medicare program) to recoup amounts so that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

NOTICES OF HEARINGS/MEETINGS

COMMITTEE ON INDIAN AFFAIRS

Mr. CAMPBELL. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, June 26, 2003, at 11:00 a.m. in Room 485 of the Russell Senate Office Building to conduct a BUSINESS MEETING on pending Committee matters.

Those wishing additional information may contact the Indian Affairs Committee at 224-2251.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, June 25, 2003, at 9:30 a.m., in open session to consider the nomination of Lieutenant General John P. Abizaid, USA, for appointment to the grade of General and to be commander, United States Central Command.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. SANTORUM. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate, on Wednesday, June 25 at 10:00 a.m. to consider pending calendar business.

On Wednesday, June 25, at 10:00 a.m., the Committee will hold a Business Meeting in Room SD-366 to consider the following items on the Agenda:

Agenda Item #3: S. 470—A bill to extend the authority for the construction of a memorial to Martin Luther King, Jr.

Agenda Item #4: S. 490—A bill to direct the Secretary of Agriculture to convey certain land in the Lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California.

Agenda Item #6: S. 546—A bill to provide for the protection of paleontological resources on Federal lands, and for other purposes.

Agenda Item #7: S. 643—A bill to authorize the Secretary of the Interior, in cooperation with the University of New Mexico, to construct and occupy a portion of the Hibben Center for Archaeological Research at the University of New Mexico.

Agenda Item #8: S. 651—A bill to amend the National Trails System Act to clarify Federal authority relating to land acquisition from willing sellers for the majority of the trails in the System, and for other purposes.

Agenda Item #9: S. 677—A bill to revise the boundary of the Black Canyon of the Gunnison National Park and Gunnison Gorge National Conservation Area in the State of Colorado, and for other purposes.