STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. JOHNSON:

S. 2561. A bill to amend title 38, United States Code, to provide for certain servicemembers to become eligible for educational assistance under the Montgomery GI Bill; to the Committee on Veterans' Affairs.

Mr. JOHNSON. Mr. President, I rise today to introduce a very important piece of legislation, the Montgomery GI Bill Enhancement Act. This bill will allow a one year open enrollment period for thousands of career military personal who are not allowed to sign up for education benefits under the Montgomery GI Bill (MGIB).

In 1976 Congress created the Veterans' Educational Assistance Program (VEAP) as a recruitment and retention tool for the post-Vietnam era. However, Congress greatly expanded education benefits in 1984 and allowed individuals with VEAP accounts to transfer their benefits to the new MGIB in 1996. The opportunity to convert to MGIB was important because the benefits available were much greater than those under VEAP.

However, those individuals who were on active duty before 1985 and did not participate in VEAP were not eligible to sign-up for MGIB, leaving a gap in available coverage for certain career military personnel. Congress has voted several times in the last decade to allow VEAP participants opportunities to transfer to MGIB, but there has never been an opportunity for those who did not have VEAP accounts to sign up for the new program, excluding them from taking advantage of MGIB educational benefits.

My bill would correct this inequity and allow individuals falling into this gap to attain MGIB benefits. Organizations such as the Non-Commissioned Officers Association, the Association of the United States Army, and the Military Coalition have come out in strong support for this legislation.

I believe that we must do more to honor our Nation's commitments to our military personnel. As the father of a soldier in the Army, I fully appreciate what a poor ''quality of life'' can do to the morale of military families. We have a long way to go, but I will continue to work with my colleagues to make sure our country's military personnel receive the benefits they deserve.

Today, there are fewer than 74,000 VEAP ''decliners'' on active duty. These men and women have dedicated their lives to a career of service to the Nation, and many are deployed in harms way leading our troops in Iraq and Afghanistan.

For these servicemen and women—many of whom are reaching retirement eligibility—time is running out. Therefore, before it is too late, I encourage my Senate colleagues to support the Montgomery GI Bill Enhancement Act and provide our servicemen and women with the benefits they deserve.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2561

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Montgomery GI Bill Enhancement Act of 2004''.

SEC. 2. OPPORTUNITY FOR CERTAIN ACTIVE-DUTY PERSONNEL TO ENROLL UNDER THE MONTGOMERY GI BILL.

(a) IN GENERAL.—Chapter 30 of title 38, United States Code, is amended by inserting after section 3018C the following new section:

''§ 3018D. Opportunity for certain active-duty personnel to enroll

''(a)(1) Notwithstanding any other provision of this chapter, during the one-year period beginning on the date of the enactment of this section, a qualified individual (described in subsection (b)) may make an irrevocable election under this section to become entitled to basic educational assistance under this chapter.

''(2) The Secretary of each military department shall provide for procedures for a qualified individual to make an irrevocable election under this section in accordance with regulations prescribed by the Secretary of Defense for the purpose of carrying out this section or which the Secretary of Homeland Security shall provide for such purpose with respect to the Coast Guard when it is not operating as a service in the Navy.

''(b) A qualified individual referred to in subsection (a) is an individual who meets each of the following requirements:

''(1) The individual first became a member of the Armed Forces or first entered on active duty as a member of the Armed Forces before July 1, 1985.

''(2) The individual has served on active duty without a break in service since the date the individual first became such a member or first entered on active duty as such a member and continues to serve on active duty for some or all of the one-year period referred to in subsection (a).

''(3) The individual, before applying for benefits under this section, has completed the requirements of a secondary school diploma (or equivalency certificate) or has successfully completed (or otherwise received academic credit for) the equivalent of 12 semester hours in a program of education leading to a standard college degree.

''(4) The individual, when discharged or released from active duty, is discharged or released therefrom with an honorable discharge.

''(c)(1) Subject to the succeeding provisions of this subsection, with respect to a qualified individual who makes an election under this section to become entitled to basic educational assistance under this chapter—

''(A) the basic pay of the qualified individual shall be reduced (in a manner determined by the Secretary concerned) until the total amount by which such basic pay is reduced is $2,700; and

''(B) to the extent that basic pay is not so reduced before the qualified individual's discharge or release from active duty as specified in subsection (b)(4), at the election of the qualified individual—

''(i) the Secretary concerned shall collect from the qualified individual; or

''(ii) the Secretary concerned shall reduce the retired or retainer pay of the qualified individual by,

an amount equal to the difference between $2,700 and the total amount of reductions under subparagraph (A), which shall be paid into the Treasury of the United States as miscellaneous receipts.

''(2)(A) The Secretary concerned shall provide for an 18-month period, beginning on the date the qualified individual makes an election under this section, for the qualified individual to pay that Secretary the amount due under paragraph (1).

''(B) Nothing in subparagraph (A) shall be construed as modifying the period of eligibility for and entitlement to basic educational assistance under this chapter applicable under section 3031 of this title.

''(d) With respect to qualified individuals referred to in subsection (c)(1)(B), no amount of educational assistance allowance under this chapter shall be paid to the qualified individual until the earlier of the date on which—

''(1) the Secretary concerned collects the applicable amount under clause (i) of such subsection; or

''(2) the retired or retainer pay of the qualified individual is first reduced under clause (ii) of such subsection.

''(e) The Secretary, in conjunction with the Secretary of Defense, shall provide for notice of the opportunity under this section to elect to become entitled to basic educational assistance under this chapter.''.

(b) CONFORMING AMENDMENTS.—Section 3017(b)(1) of such title is amended—

(1) in subparagraphs (A) and (C), by striking ''or 3018C(e)'' and inserting ''3018C(e), or 3018D(c)''; and

(2) in subparagraph (B), by inserting ''or 3018D(c)'' after ''under section 3018C(e)''.

(c) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 30 of such title is amended by inserting after the item relating to section 3018C the following new item:

''3018D. Opportunity for certain active-duty personnel to enroll.''.

By Mr. BAUCUS:

S. 2562. A bill to amend title XVIII of the Social Security Act provide incentives for the furnishing of quality care under Medicare Advantage plans and by end stage renal disease providers and facilities, and for other purposes; to the Committee on Finance.

Mr. BAUCUS. Mr. President, I rise today to introduce the ''Medicare Quality Improvement Act of 2004.''

This bill will establish a new payment incentive structure for quality health care, starting with the Medicare Advantage and End Stage Renal Disease programs. Under this policy, Medicare would give a financial boost to plans and renal care providers demonstrating the highest quality care and a bonus to those that are working hard to improve.

Why focus on quality? I hear from all corners that the U.S. health care system is unsustainable in its current form. Costs are rising, and the care provided is not always appropriate or necessary. Not to mention that 43 million Americans lack health insurance.

As I travel around Montana, I hear so much from so many constituents about the rising cost of health care. Countless parents tell me they are struggling to pay for health care for their families, afraid that one more illness will force them into bankruptcy. Working people tell me they fear their employers will raise their premiums or drop

coverage altogether due to rising health care costs. And employers, both large industries and small enterprises, tell me they face competition from companies in countries where healthcare is significantly less expensive. While these employers are trying to keep jobs at home, health care costs are pushing them abroad.

And most recently, my personal experience with the health care system has brought the issue of health costs and quality even closer to home.

A few weeks ago, I chose to have an elective procedure to keep my heart healthy. I have excellent health care coverage, and I was able to seek out excellent doctors and nurses at the Mayo Clinic. In short, I am fortunate that the care I received was high-quality care. The doctors and nurses who took care of me were on the ball—making sure I got the right medications with no dangerous interactions, using proper surgical safety so I wouldn't get an infection, and providing good follow-up care so I could get back to my family and back to work.

My experience with the health system was a positive one. Unfortunately, not everyone is as lucky. Ninety-eight thousand people die every year in this country as a result of medical errors. That's 270 people each day. An appalling statistic. Many of these deaths can be prevented, and we must work to make sure that they are.

In addition to the cases of medical error we know about, there are many that go unreported and even undetected. Studies have shown that patients in the U.S. receive recommended care and treatment when they visit the doctor or hospital only about half of the time. Failure to follow proper patterns of care or recommended guidelines can lead to poor outcomes, and it is also more expensive in the short and long run.

Errors can mean more trips to the hospital or to the doctor, more drugs, and sometimes even additional surgeries. Each preventable medication error costs about $4,700 in added hospital costs alone, not to mention the personal costs of childcare and lost wages, and the societal costs of lost productivity.

While not as fatal as actual errors, missed health care opportunities also carry a cost. Each year, missed health care opportunities—inappropriate care and generally poor quality care costs the U.S. health system more than $1 billion dollars in avoidable hospital bills and 41 million lost work days, which costs American businesses about $11.5 billion. Improving the quality of health care can reduce health care costs and stimulate our economy. In a time of slow economic growth and large deficits, health care is a compelling place to start.

Last year's Medicare Modernization Act got the ball rolling. The Medicare bill ties hospital reimbursement to reporting data on specific quality indicators. And hospitals are responding. Today, almost 2,000 hospitals are sharing data with the Centers for Medicare and Medicaid on at least one of the quality measures. Knowing more about the care that is delivered across the country should help us target incentives and resources to improve quality. It also provides employers and patients with new information about where to find the best deal for their health care dollar. And it also provides hospitals a way to compare their performance to other hospitals.

The bill I am introducing today builds on this strong start. It would establish a mechanism to pay for quality in the Medicare Advantage and End Stage Renal Disease Programs, through bonus payments for the best quality nationwide and bonuses for improving from one year to the next. Rewards for improvement are an important piece of my proposal—last year, the top ten percent of health plans in the country reported perfect scores on a set of quality indicators. There is no doubt that they deserve recognition. But we don't want to leave behind smaller or historically poorer-performing organizations that are making major strides to improve.

Medicare Advantage plans, which tend to utilize a coordinated model of care, have a unique opportunity to impact a patient's health outcomes—plans have access to information about a patient's medical history, and can follow patients more closely to ensure that they are receiving appropriate preventive, acute, and follow-up care. Medicare Advantage plans can translate their own payments into quality incentives downstream. They can reward providers for performing certain procedures known to be effective, or for prescribing drugs known to have equal or greater effectiveness at a reduced cost. And they can improve a beneficiary's preventive and wellness benefits.

Dialysis clinics that participate in Medicare through the program for patients with End Stage Renal Disease have a momentous mission, helping these patients enjoy life for years longer than we might have thought possible just a few decades ago. Because dialysis is such a complex operation, quality of care is extremely important.

Plans and providers in the Medicare Advantage and ESRD programs have already started measuring and reporting on quality, which makes them an excellent place to start. But I want to be clear these programs should not be singled out simply because they are ahead of the game. Working with ESRD providers and Medicare Advantage plans heralds the beginning of a longer journey, and we need to stay the course.

First, we need to monitor this quality incentive program and ensure that the methods used to measure health care quality and evaluate performance are evidence-based and valid.

Second, we should evaluate the impact of a pay-for-performance program on health plans and providers—particularly small organizations and those that are just entering the market. Additionally, because last year's Medicare legislation made payment and policy changes to these providers—for example, a short-term payment increase for ESRD and a new payment policy and the addition of regional plans for Medicare Advantage—we would need to keep a close eye on the consequences of these changes and the interaction with the pay-for-performance quality initiative and take action where necessary.

Third, we should look with a wide lens and move forward with quality initiatives in all government health care programs. It is our responsibility to set an example for the industry through quality improvement programs in Medicare and Medicaid, including traditional fee-for-service Medicare.

As I mentioned, the National Voluntary Hospital Reporting Initiative is a groundbreaking program, but we need to do more in traditional Medicare to encourage high quality care. My bill sketches out a roadmap that will lead us toward expanding the quality measures currently collected for fee-for-service providers, and ultimately toward additional Medicare payment systems that promote quality improvement.

We can also do more to focus on quality care in Medicaid. Today, there are a number of people at the Centers for Medicare and Medicaid Services whose responsibility it is to improve the quality of care in Medicare. On the Medicaid side, there is one person—one person who, while given the responsibility for quality, has no resources or authority to develop program innovations.

You might say that quality is already addressed in Medicaid. I applaud my colleague and Chairman of the Finance Committee, Senator GRASSLEY, for encouraging CMS to increase its quality improvement activities for home and community-based services in Medicaid. We should build on this foundation and broaden the effort. We need to identify barriers to quality improvement throughout the Medicaid program, and take steps toward removing those barriers.

The bill I introduce today would target a few of those barriers, and it would require further studies to identify others. It authorizes money to hire new staff—experienced health professionals—to improve the quality and coordination of care delivered to Medicaid beneficiaries. It explores ways to integrate data on Medicaid beneficiaries who are also enrolled in Medicare—the dual-eligibles and coordinate the care they receive from both programs. Many dual-eligibles are among the sickest and costliest beneficiaries. By better coordinating their care we can improve health outcomes and save money in both programs at once.

As you can tell, I have a lot of ideas. But I have only scratched the surface of this issue and am deeply committed to working with my colleagues in the

Senate to move forward. This bill is a good start, but it is just that—a start. We must do more.

Many of my colleagues in the Senate also care deeply about improving the health care system, and I commend their efforts to develop courageous proposals that will spark change. Senator CLINTON introduced a bill last year, the Health Information for Quality Improvement Act. More recently, Senator KENNEDY Introduced the Health Care Modernization, Cost Reduction, and Quality Improvement Act.

These bills lay out a comprehensive array of policies to improve health care quality and reduce costs, and my bill focuses on one piece of that picture—paying for quality. They represent the gold standard toward which we should all be working. But we share a common goal to make the most of the American health care dollar, so that we can provide better care to more people.

As I mentioned, health care in this country is more expensive than it is elsewhere. But we don't necessarily get more for our money. The United States spends twice as much on health care than any other country, but studies have shown that quality is about the same. Better in some areas, worse in others, but all in all about the same. No matter how you cut it, that means that the value of our health care—what we are getting for each dollar is less in the United States than in other developed countries.

I've always believed that Americans were all about value. We are the country of start-up companies and the home of Wal-Mart. We know about good business, and we know about hard work. We should know more—and do more—about health care.

We are an amazing country, but today our health care system is sick. Why? It is not the fault of hard-working doctors and nurses who put in long hours to make their patients healthy. It is our fault. We need to support the work of health care professionals by providing the right resources and designing payment systems to promote quality. Today, it takes an average 17 years for a new discovery in medical care to move from the lab bench into regular clinical practice. And for providers working in settings without regular Internet access or without the luxury of time to peruse medical journals, it may take even longer. As Members of Congress, we have the opportunity to change the system, to provide incentives for good care, funding for research into best medical practices, and to require the development and reporting of quality measures.

The road to this goal is long and difficult. I call on my colleagues for their energy and support, and I call on health care professionals and the health insurance industry to work with us. This is challenging work, and involves many difficult decisions. But I've never been one to shirk a challenge, and I hope you will join me. This bill is the beginning of what must be a strong bipartisan push to improve our health care system—to increase quality of care, to reduce costs, and to strengthen the American spirit.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2562

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) IN GENERAL.—This Act may be cited as the ''Medicare Quality Improvement Act of 2004''.

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

SEC. 2. FINDINGS.

The Senate makes the following findings:

(1) The Institute of Medicine has highlighted problems with our health care system in the areas of quality and patient safety.

(2) The New England Journal of Medicine has published research in an article entitled ''The Quality of Health Care Delivered to Adults in the United States'' showing that adults in the United States receive recommended health care only about ½ of the time.

(3) Payment policies under the medicare program do not include mechanisms designed to improve the quality of care.

(4) The medicare program should reward health care providers who show, through measurement and reporting of quality indicators and through the practice of innovations, that they are working to deliver high quality health care to their patients.

(5) Reimbursement for services provided under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act should be based on a pay-for-performance system.

(6) A more aggressive research agenda on the development of appropriate quality measurement and payment methodologies under the medicare program is necessary.

SEC. 3. MEDICARE ADVANTAGE AND REASONABLE COST REIMBURSEMENT CONTRACT QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAM.

(a) PROGRAM.—Part C of title XVIII of the Social Security Act, as amended by section 241 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2214), is amended by adding at the end the following new section:

''QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAM

''SEC. 1860C–2. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which financial incentive payments are provided each year to Medicare Advantage organizations offering Medicare Advantage plans and organizations that are providing benefits under a reasonable cost reimbursement contract under section 1876(h) that demonstrate the provision of superior quality health care to enrollees under the plan or contract.

''(2) PROGRAM TO BEGIN IN 2007.—The Secretary shall establish the program so that National Performance Quality Payments (described in subsection (c)) and National Quality Improvement Payments (described in subsection (d)) are made with respect to 2007 and each subsequent year.

''(3) REQUIREMENT.—In order for an organization to be eligible for a financial incentive payment under this section with respect to a Medicare Advantage plan or a reasonable cost reimbursement contract under section 1876(h), the organization shall—

''(A) provide for the collection, analysis, and reporting of data pursuant to sections 1852(e)(3) and 1876(h)(8), respectively, with respect to the plan or contract; and

''(B) not later than a date specified by the Secretary during each baseline year (as defined in subsection (d)(4)), submit such data on the quality measures described in subsection (e)(2) as the Secretary determines appropriate for the purpose of establishing a baseline with respect to the plan or contract.

''(4) USE OF MOST RECENT DATA.—Financial incentive payments under this section shall be based upon the most recent available quality data.

''(5) TIMING OF QUALITY INCENTIVE PAYMENTS.—The Secretary shall ensure that financial incentive payments under this section with respect to a year are made by March 1 of the subsequent year.

''(6) APPLICABILITY OF PROGRAM TO MA PLANS.—For purposes of this section, the term 'Medicare Advantage plan' shall—

''(A) include both MA regional plans and MA local plans; and

''(B) not include an MA plan described in subparagraph (A)(ii) or (B) of section 1851(a)(2).

''(b) QUALITY INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—Beginning with 2007, the Secretary shall allocate the total amount available for financial incentive payments in the year under subsection (f) as follows:

''(A) The per beneficiary payment amount for National Performance Quality Payments established under paragraph (2) shall be greater than the per beneficiary payment amount for National Quality Improvement Payments established under such paragraph.

''(B) With respect to National Performance Quality Payments, the per beneficiary payment amount established under paragraph (2) shall be greatest for the organizations offering the highest performing plans or contracts.

''(C) With respect to National Quality Improvement Payments, the per beneficiary

payment amount established under paragraph (2) shall be greatest for the organizations offering plans or contracts with the highest degree of improvement.

''(2) AMOUNT OF QUALITY INCENTIVE PAYMENT.—

''(A) IN GENERAL.—The amount of a financial incentive payment under subsection (c) or (d) to a Medicare Advantage organization with respect to a Medicare Advantage plan or to an organization with respect to a reasonable cost reimbursement contract under section 1876(h) shall be determined by multiplying the number of beneficiaries enrolled under the plan or contract on the first day of the year for which the payment is provided by a dollar amount established by the Secretary (in this section referred to as the 'per beneficiary payment amount') that is the same for all beneficiaries enrolled under the plan or contract.

''(B) LIMITATION ON TOTAL AMOUNT OF QUALITY INCENTIVE PAYMENTS.—The total amount of all the financial incentive payments given with respect to a year shall be equal to the amount available for such payments in the year under subsection (f).

''(3) USE OF QUALITY INCENTIVE PAYMENTS.—Financial incentive payments received under this section may only be used for the following purposes:

''(A) To reduce any beneficiary cost-sharing applicable under the plan or contract.

''(B) To reduce any beneficiary premiums applicable under the plan or contract.

''(C) To initiate, continue, or enhance health care quality programs for enrollees under the plan or contract.

''(D) To improve the benefit package under the plan or contract.

''(4) REPORTING ON USE OF QUALITY INCENTIVE PAYMENTS.—Beginning in 2008, each MA organization that receives a financial incentive payment under this section shall report to the Secretary pursuant to section 1854(a)(7) on how the organization will use such payment.

''(5) LIMITATIONS ON QUALITY INCENTIVE PAYMENTS.—

''(A) PLAN ONLY ELIGIBLE FOR 1 PAYMENT IN A YEAR.—A Medicare Advantage organization offering a Medicare Advantage plan or an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h) may not receive more than 1 financial incentive payment under this section in a year with respect to such plan or contract. If an organization with respect to the plan or contract is eligible for a National Performance Quality Payment and a National Quality Improvement Payment, the organization shall be given the National Performance Quality Payment.

''(B) PLAN MUST BE AVAILABLE FOR ENTIRE YEAR.—A Medicare Advantage organization offering a Medicare Advantage plan or an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h) is not eligible for a financial incentive payment under this section with respect to such plan or contract unless the plan or contract offers benefits throughout the year in which the payment is provided.

''(c) NATIONAL PERFORMANCE QUALITY PAYMENTS.—The Secretary shall make National Performance Quality Payments to the Medicare Advantage organizations and organizations offering reasonable cost reimbursement contracts under section 1876(h) with respect to each Medicare Advantage plan or reasonable cost contract offered by the organization that receives ratings for the year in the top applicable percent of all plans and contracts rated by the Secretary pursuant to subsection (e) for the year. For purposes of the preceding sentence, the term 'applicable percent' means a percent determined appropriate by the Secretary in consultation with the Quality Advisory Board, but in no case less than 20 percent.

''(d) NATIONAL QUALITY IMPROVEMENT PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall make National Quality Improvement Payments to Medicare Advantage organizations and organizations offering reasonable cost reimbursement contracts under section 1876(h) with respect to each Medicare Advantage plan or reasonable cost reimbursement contract offered by the organization that receives a rating under subsection (e) for the payment year that exceeds the rating received under such subsection for the plan or contract for the baseline year.

''(2) NATIONAL IMPROVEMENT STANDARD.—Beginning with 2009, the Secretary may implement a national improvement standard that Medicare Advantage plans and reasonable cost reimbursement contracts must meet in order to receive a National Quality Improvement Payment.

''(3) APPLICATION OF THRESHOLDS.—In determining whether a rating received under subsection (e) for the payment year exceeds the rating received under such subsection for the baseline year, the Secretary shall hold any applicable thresholds constant. For purposes of the preceding sentence, the term 'threshold' means norms used to assess performance.

''(4) BASELINE YEAR DEFINED.—In this subsection, the term 'baseline year' means the year prior to the payment year.

''(e) RATING METHODOLOGY.—

''(1) SCORING AND RANKING SYSTEMS.—

''(A) IN GENERAL.—The Secretary shall develop separate scoring and ranking systems for purposes of determining which organizations offering Medicare Advantage plans and reasonable cost reimbursement contracts under section 1876(h) qualify for—

''(i) National Performance Quality Payments; and

''(ii) National Quality Improvement Payments.

''(B) REQUIREMENTS.—In developing, implementing, and updating the scoring and ranking systems, the Secretary shall—

''(i) consult with the Quality Advisory Board established under section 1898;

''(ii) take into account the report on health care performance measures submitted by the Institute of Medicine of the National Academy of Sciences under section 238 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

''(iii) take into account the Managed Care Organization (MCO) standards and guideline methodology of the National Committee for Quality Assurance for awarding total Health Plan Employer Data and Information Set (HEDIS) points (based on HEDIS and Consumer Assessment of Health Plans Survey (CAHPS) measures).

''(2) MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), in developing the scoring and ranking systems under paragraph (1), the Secretary shall use all measures determined appropriate by the Secretary. Such measures may include—

''(i) outcome measures for highly prevalent chronic conditions;

''(ii) audited HEDIS outcomes and process measures, CAHPS data, and other data reported to the Department of Health and Human Services; and

''(iii) the Joint Commission on Accreditation of Healthcare Organizations core measures.

''(B) SCORING AND RANKING SYSTEM FOR NATIONAL PERFORMANCE QUALITY PAYMENTS ONLY BASED ON MEASURES OF CLINICAL EFFECTIVENESS.—The scoring and ranking system for National Performance Quality Payments shall only include measures of clinical effectiveness.

''(3) WEIGHTS OF MEASURES.—In developing the scoring and ranking systems under paragraph (1), the Secretary shall assign weights to the measures used by the Secretary under such system pursuant to paragraph (2). In assigning such weights, the Secretary shall provide greater weight to the measures that measure clinical effectiveness.

''(4) RISK ADJUSTMENT.—In developing the scoring and ranking systems under paragraph (1), the Secretary shall establish procedures for adjusting the data used under the system to take into account differences in the health status of individuals enrolled under Medicare Advantage plans and reasonable cost contracts.

''(5) UPDATE.—

''(A) IN GENERAL.—The Secretary shall as determined appropriate, but in no case more often than once each 12-month period, update the scoring and ranking systems developed under paragraph (1), including the measures used by the Secretary under such system pursuant to paragraph (2), the weights established pursuant to paragraph (3), and the risk adjustment procedures established pursuant to paragraph (4).

''(B) COMPARISON FOR NATIONAL QUALITY IMPROVEMENT PAYMENTS.—Each update under subparagraph (A) of the scoring and ranking system for National Quality Improvement Payments shall allow for the comparison of data from one year to the next for purposes of identifying which plans or contracts will receive such Payments.

''(C) CONSULTATION.—In determining when and how to update the scoring and ranking systems under subparagraph (A), the Secretary shall consult with the Quality Advisory Board.

''(f) FUNDING OF PAYMENTS.—The amount available for financial incentive payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the amendments made by section 3(b) of the Medicare Quality Improvement Act of 2004.''.

(b) REDUCTION IN PAYMENTS TO ORGANIZATIONS IN ORDER TO FUND PROGRAM.—

(1) MA PAYMENTS.—

(A) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)), as added by section 222(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2200), is amended—

(i) in subparagraphs (A) and (B) of paragraph (1), by inserting ''and, beginning in 2007, reduced by 2 percent in the case of an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2)'' before the semicolon at the end; and

(ii) in paragraph (2), by inserting ''and, beginning in 2007, reduced by 2 percent in the case of an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2)'' before the period at the end.

(B) REDUCTIONS IN PAYMENTS DO NOT EFFECT THE GOVERNMENT SAVINGS FOR BIDS BELOW THE BENCHMARK.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)), as added by section 222(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2196), is amended—

(i) by striking ''75 percent'' and inserting ''100 percent''; and

(ii) by inserting the following before the period at the end: '', reduced by 25 percent of such average per capita savings (if any), as applicable to the plan and year involved, that would be computed if sections 1853(j) and 1860C–1(e)(1) was applied by substituting

'zero percent' for '2 percent' each place it appears''.

(2) REASONABLE COST CONTRACT PAYMENTS.—Section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)) is amended by adding at the end the following new paragraph:

''(6) Notwithstanding the preceding provisions of this subsection, the Secretary shall reduce each payment to an eligible organization under this subsection with respect to benefits provided on or after January 1, 2007, by an amount equal to 2 percent of the payment amount. The preceding sentence shall have no effect on payments to eligible organizations for the provision of qualified prescription drug coverage under part D.''.

(3) CCA PAYMENTS.—The first sentence of section 1860C–1(e)(1) of the Social Security Act, as added by section 241 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2214) is amended by inserting '', reduced by 2 percent in the case of an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2)'' before the period at the end.

(c) REQUIREMENT FOR REPORTING ON USE OF FINANCIAL INCENTIVE PAYMENTS.—

(1) MA PLANS.—Section 1854(a) of the Social Security Act (42 U.S.C. 1395w–24(a)), as amended by section 222(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2193), is amended—

(A) in paragraph (1)(A)(i), by striking ''or (6)(A)'' and inserting ''(6)(A), or (7)''; and

(B) by adding at the end the following:

''(7) SUBMISSION OF INFORMATION OF HOW FINANCIAL INCENTIVE PAYMENTS WILL BE USED BEGINNING IN 2008.—For an MA plan described in subparagraph (A)(i) or (C) of section 1851(a)(2) for a plan year beginning on or after January 1, 2008, the information described in this paragraph is a description of how the organization offering the plan will use any financial incentive payment that the organization received under section 1860C–2 with respect to the plan.''.

(2) ELIGIBLE ENTITIES WITH REASONABLE COST CONTRACTS.—Section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)), as amended by subsection (b)(2), is amended by adding at the end the following new paragraph:

''(7)(A) Not later than July 1 of each year (beginning in 2008), any eligible entity with a reasonable cost reimbursement contract under this subsection that receives a financial incentive payment under section 1860C–2 with respect to each plan year shall submit to the Secretary a report containing the information described in subparagraph (B).

''(B) The information described in this subparagraph is a description of how the organization offering the plan will use any financial incentive payment that the organization received under section 1860C–2 with respect to the plan.''.

(d) SUBMISSION OF QUALITY DATA.—

(1) MA ORGANIZATIONS.—Section 1852(e) of the Social Security Act (42 U.S.C. 1395w–22(e)), as amended by section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2347), is amended—

(A) in paragraph (1), by striking ''an MA private fee-for-service plan or''; and

(B) by striking paragraph (3) and inserting the following new paragraph:

''(3) COLLECTION, ANALYSIS, AND REPORTING.—

''(i) IN GENERAL.—As part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

''(ii) COORDINATION WITH COMMERCIAL ENROLLEE REPORTING REQUIREMENTS.—The Secretary shall establish procedures to ensure the coordination of the reporting requirement under clause (i) with reporting requirements for the organization under this part relating to individuals enrolled with the organization but not under this part. Although such reporting requirements shall be coordinated pursuant to the preceding sentence, the use of the data reported may vary.''.

(2) ELIGIBLE ENTITIES WITH REASONABLE COST CONTRACTS.—Section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)), as amended by subsection (c)(2), is amended by adding at the end the following new paragraph:

''(8)(A) With respect to plan years beginning on or after January 1, 2006, an eligible entity with a reasonable cost reimbursement contract under this subsection shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

''(B) The Secretary shall establish procedures to ensure the coordination of the reporting requirement under subparagraph (A) with reporting requirements for the entity under this title relating to individuals enrolled with the entity but not receiving benefits under this title.''.

SEC. 4. QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAM FOR PROVIDERS AND FACILITIES THAT PROVIDE SERVICES TO MEDICARE BENEFICIARIES WITH ESRD.

Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)), as amended by section 623(d)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2313), is amended—

(1) in paragraph (11)(B), by striking ''paragraphs (12) and (13)'' and inserting ''paragraphs (12), (13), and (14)'';

(2) in paragraph (12), by striking ''In lieu of'' and inserting ''Subject to paragraph (14), in lieu of'';

(3) in paragraph (13)(A), in the matter preceding clause (i), by striking ''The payment amounts'' and inserting ''Subject to paragraph (14), the payment amounts''; and

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

''(14) RENAL DIALYSIS PERFORMANCE INCENTIVE PAYMENT PROGRAM.—

''(A) ESTABLISHMENT OF PROGRAM.—

''(i) IN GENERAL.—The Secretary shall establish a program under which financial incentive payments are provided each year to providers of services and renal dialysis facilities that receive payments under paragraph (12) or (13) and demonstrate the provision of superior quality health care to individuals with end stage renal disease.

''(ii) PROGRAM TO BEGIN IN 2007.—The Secretary shall establish the program so that National Performance Quality Payments (described in subparagraph (C)) and National Quality Improvement Payments (described in subparagraph (D)) are made with respect to 2007 and each subsequent year.

''(iii) REQUIREMENT.—In order for a provider of services or a renal dialysis facility to be eligible for a financial incentive payment under this section, the provider or facility shall, not later than a date specified by the Secretary during the baseline year (as defined in subparagraph (D)(iv)), submit such data on the quality measures as the Secretary determines appropriate for the purpose of establishing a baseline with respect to the provider or facility.

''(iv) USE OF MOST RECENT DATA.—Financial incentive payments under this paragraph shall be based upon the most recent available quality data as provided by the Consolidated Renal Operations in a Web-enabled Network (CROWN) system.

''(v) PEDIATRIC FACILITIES NOT INCLUDED IN PROGRAM.—For purposes of this paragraph, including subparagraph (F)(i), the terms 'renal dialysis facility' and 'facility' do not include a renal dialysis facility at least 50 percent of whose patients are individuals under 18 years of age.

''(B) PAYMENTS.—

''(i) IN GENERAL.—Beginning with 2007, the Secretary shall allocate the total amount available for financial incentive payments in the year under subparagraph (F)(ii) as follows:

''(I) The amount allocated for National Performance Quality Payments shall be greater than the amount allocated for National Quality Improvement Payments.

''(II) With respect to National Performance Quality Payments, the per capita amount of the payments shall be greatest for the organizations offering the highest performing plans or contracts.

''(III) With respect to National Quality Improvement Payments, the per capita amount of the payments shall be greatest for the organizations offering plans or contracts with the highest degree of improvement.

''(ii) AMOUNT OF QUALITY INCENTIVE PAYMENT.—

''(I) IN GENERAL.—The amount of a financial incentive payment under subparagraph (C) or (D) to a provider of services or renal dialysis facility shall be determined by multiplying the number of beneficiaries who received dialysis services from the provider or facility during the year for which the payment is provided by a dollar amount established by the Secretary that is the same with respect to each beneficiary receiving dialysis services from the provider or facility.

''(II) LIMITATION ON TOTAL AMOUNT OF QUALITY INCENTIVE PAYMENTS.—The total amount of all the financial incentive payments given with respect to a year shall be equal to the amount available for such payments in the year under subparagraph (F)(ii).

''(iii) USE OF QUALITY INCENTIVE PAYMENTS.—Financial incentive payments received under this paragraph may be used for the following purposes:

''(I) To invest in information technology systems that will improve the quality of care provided to individuals with end stage renal disease.

''(II) To initiate, continue, or enhance health care quality programs for individuals with end stage renal disease.

''(III) Any other purpose determined appropriate by the Secretary.

''(iv) LIMITATIONS ON QUALITY INCENTIVE PAYMENTS.—

''(I) ONLY ELIGIBLE FOR 1 PAYMENT IN A YEAR.—A provider of services or a renal dialysis facility may not receive more than 1 financial incentive payment under this paragraph in a year. If a provider of services or a renal dialysis facility is eligible for a National Performance Quality Payment and a National Quality Improvement Payment, the organization shall be given the National Performance Quality Payment.

''(II) SERVICES MUST BE AVAILABLE FOR ENTIRE YEAR.—A provider of services or renal dialysis facility is not eligible for a financial incentive payment under this paragraph unless the provider or facility is in operation and providing dialysis services for the entire year for which the payment is provided.

''(C) NATIONAL PERFORMANCE QUALITY PAYMENTS.—The Secretary shall make National Performance Quality Payments to the providers of services and renal dialysis facilities that receive ratings for the year in the top applicable percent of all providers and facilities rated by the Secretary pursuant to subparagraph (E) for the year. For purposes of the preceding sentence, the term 'applicable percent' means a percent determined appropriate by the Secretary in consultation with

the Quality Advisory Board, but in no case less than 20 percent.

''(D) NATIONAL QUALITY IMPROVEMENT PAYMENTS.—

''(i) IN GENERAL.—National Quality Improvement Payments shall be paid to each provider of services and renal dialysis facility that receives ratings under subparagraph (E) for the payment year that exceed the ratings received under such subparagraph for the provider or facility for the baseline year.

''(ii) NATIONAL IMPROVEMENT STANDARD.—Beginning with 2009, the Secretary shall have the authority to implement a national improvement standard that providers of services and renal dialysis facilities must meet in order to receive a National Quality Improvement Payment.

''(iii) APPLICATION OF THRESHOLDS.—In determining whether a rating received under subparagraph (E) for the payment year exceeds the rating received under such subsection for the baseline year, the Secretary shall hold any applicable thresholds constant.

''(iv) BASELINE YEAR DEFINED.—In this subparagraph, the term 'baseline year' means the year prior to the payment year.

''(E) RATING METHODOLOGY.—

''(i) SCORING AND RANKING SYSTEMS.—

''(I) IN GENERAL.—The Secretary shall develop separate scoring and ranking systems for purposes of determining which providers of services and renal dialysis facilities qualify for—

''(aa) National Performance Quality Payments; and

''(bb) National Quality Improvement Payments.

''(II) REQUIREMENTS.—In developing, implementing, and updating the scoring and ranking systems, the Secretary shall—

''(aa) consult with the Quality Advisory Board established under section 1898 and the network administrative organizations designated under subsection (c)(1)(A)(i)(II); and

''(bb) take into account the report on health care performance measures submitted by the Institute of Medicine of the National Academy of Sciences under section 238 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

''(ii) MEASURES.—

''(I) IN GENERAL.—Subject to subclause (II), in developing the scoring and ranking system under clause (i), the Secretary shall use all measures determined appropriate by the Secretary. Such measures may include the following:

''(aa) The measures profiled in the ESRD Clinical Performance Measures (CPM) project of the Centers for Medicare & Medicaid Services.

''(bb) The measures for bone disease to be determined by the K-DOQI project of the National Kidney Foundation.

''(II) Scoring and ranking system for national performance quality payments only based on measures of clinical effectiveness.—The scoring and ranking system for National Performance Quality Payments shall only include measures of clinical effectiveness.

''(iii) WEIGHTS OF MEASURES.—In developing the scoring and ranking systems under clause (i), the Secretary shall assign weights to the measures used by the Secretary under such system pursuant to clause (ii). In assigning such weights, the Secretary shall provide greater weight to the measures that measure clinical effectiveness.

''(iv) RISK ADJUSTMENT.—In developing the scoring and ranking systems under clause (i), the Secretary shall establish procedures for adjusting the data used under the system to take into account differences in the health status of individuals receiving dialysis services from providers of services and renal dialysis facilities.

''(v) UPDATE.—

''(I) IN GENERAL.—The Secretary shall as determined appropriate, but in no case more often than once each 12-month period, update the scoring and ranking systems developed under clause (i), including the measures used by the Secretary under such system pursuant to clause (ii), the weights established pursuant to clause (iii), and the risk adjustment procedures established pursuant to clause (iv).

''(II) COMPARISON FOR NATIONAL QUALITY IMPROVEMENT PAYMENTS.—Each update under subclause (I) of the National Quality Improvement Payments shall allow for the comparison of data from one year to the next for purposes of identifying which providers of services and renal dialysis facilities will receive such Payments.

''(III) CONSULTATION.—In determining when and how to update the scoring and ranking systems under subclause (I), the Secretary shall consult with the Quality Advisory Board.

''(F) FUNDING OF PAYMENTS.—

''(i) REDUCTION IN PAYMENTS.—In order to provide the funding for the financial incentive payments under this paragraph, for each year (beginning with 2007), the Secretary shall reduce each payment under paragraphs (12) and (13) to a provider of service and a renal dialysis facility by an amount equal to 2 percent of the payment.

''(ii) AMOUNT AVAILABLE.—The amount available for financial incentive payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the application of clause (i).''.

SEC. 5. MEDICARE INNOVATIVE QUALITY PRACTICE AWARD PROGRAM.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a program under which the Secretary shall award bonus payments to entities and individuals providing items and services under the medicare program under title XVIII of the Social Security Act that demonstrate innovative practices, structural improvements, or capacity enhancements that improve the quality of health care provided to medicare beneficiaries by such entities and individuals.

(b) PERIOD OF PROGRAM.—Awards under the program shall be made during 2006, 2007, and 2008.

(c) SELECTION OF RECIPIENTS.—

(1) IN GENERAL.—The Secretary shall ensure that the entities and individuals that receive an award under this section have demonstrated improvements in the quality of health care provided to medicare beneficiaries by such entities and individuals through comparison with a control group or baseline evaluation. For purposes of the program, improvements in the quality of health care provided to medicare beneficiaries shall be defined as providing additional services, such as translator services and health literacy education services, or providing care to an expanded service area or an expanded population through telemedicine, increased cultural competence, or other means, in combination with improved health outcomes or reduced beneficiary costs.

(2) ALL ENTITIES AND INDIVIDUALS ELIGIBLE.—Any entity, including a plan, or individual that is providing services under the medicare program is eligible for receiving an award under this section.

(3) CONSULTATION.—In selecting the recipients of the awards under this section, the Secretary shall consult with the Quality Advisory Board established under section 1898 of the Social Security Act, as added by section 7.

(d) MINIMUM NUMBER OF AWARDS.—The Secretary shall make at least 10 awards under this section in each year of the program.

(e) APPLICATION.—An entity or individual desiring an award under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

(f) AMOUNT OF AWARD.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (h), the Secretary shall determine the amount of awards under this section.

(2) REQUIREMENT.—In determining the amount of awards under this section, the Secretary shall ensure that—

(A) no single award is excessive; and

(B) consideration is given to the number of beneficiaries served by the entity or individual receiving the award.

(g) REPORT.—Not later than 6 months after the date on which the program established under subsection (a) ends, the Secretary shall submit to Congress a report on the program together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(h) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $10,000,000 for each of 2006, 2007, and 2008 to carry out this section.

SEC. 6. QUALITY IMPROVEMENT DEMONSTRATION PROGRAM FOR PEDIATRIC RENAL DIALYSIS FACILITIES PROVIDING CARE TO MEDICARE BENEFICIARIES WITH END STAGE RENAL DISEASE.

(a) DEMONSTRATION PROJECTS.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a 3-year demonstration program under which the Secretary establishes demonstration projects that encourage pediatric dialysis facilities to provide superior quality health care to individuals with end stage renal disease.

(2) CONSULTATION IN SELECTING SITES.—In selecting the demonstration project sites under this section, the Secretary shall consult with the Quality Advisory Board established under section 1898 of the Social Security Act, as added by section 7.

(3) SUBMISSION OF QUALITY DATA.—Under the demonstration projects, demonstration sites shall select appropriate measures of quality of care provided to individuals eligible for benefits under title XVIII of the Social Security Act who are under 18 years of age and shall report data on such measures to the Secretary.

(4) ASSESSMENT OF MEASURES.—The Secretary, in consultation with the Quality Advisory Board, shall assess the validity and reliability of the measures selected under paragraph (2).

(b) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

(c) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures made by the Secretary do

not exceed the amount which the Secretary would have expended if the demonstration program under this section was not implemented.

(d) REPORT.—Not later than 6 months after the date on which the demonstration program established under this section ends, the Secretary shall prepare and submit to Congress a report on the demonstration program together with—

(1) recommendations on whether pediatric renal dialysis facilities should be included in the renal dialysis performance payment program under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)), as added by section 4(4); and

(2) such recommendations for legislation or administrative action as the Secretary determines appropriate.

(e) PEDIATRIC RENAL DIALYSIS FACILITY DEFINED.—The term ''pediatric renal dialysis facility'' means a renal dialysis facility that receives payments under paragraph (12) or (13) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) and is not eligible to participate in the renal dialysis performance payment program under paragraph (14) of such section (as added by section 4(4)) because of the application of subparagraph (A)(iv) of such paragraph.

SEC. 7. MEDICARE QUALITY ADVISORY BOARD.

Title XVIII of the Social Security Act, as amended by section 1016 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2447), is amended by adding at the end the following new section:

''QUALITY ADVISORY BOARD

''SEC. 1898. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare Quality Advisory Board (in this section referred to as the 'Board').

''(b) MEMBERSHIP AND TERMS.—

''(1) IN GENERAL.—Subject to paragraphs (3), (4), and (5), the Board shall be composed of representatives described in paragraph (2) who shall serve for such term as the Secretary may specify.

''(2) REPRESENTATIVES.—Representatives described in this subparagraph include representatives of the following:

''(A) Patients or patient advocate organizations.

''(B) Individuals with expertise in the provision of quality care, such as medical directors, heads of hospital quality improvement committees, health insurance plan representatives, and academic researchers.

''(C) Health care professionals and providers.

''(D) Organizations that focus on the measurement and reporting of quality indicators.

''(E) State government health care programs.

''(3) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Board.

''(4) EXPERIENCE WITH URBAN AND RURAL HEALTH CARE ISSUES.—The membership of the Board should be representative of individuals with experience with urban health care issues and individuals with experience with rural health care issues.

''(5) EXPERIENCE ACROSS A SPECTRUM OF ACTIVITIES.—The membership of the Board should be representative of individuals with experience across the spectrum of activities that the Secretary is responsible for with respect to this title, including the coverage of new services and technologies, payment rates and methodologies, beneficiary services, and claims processing.

''(c) DUTIES.—

''(1) INCENTIVE PROGRAMS.—

''(A) ADVICE.—The Board shall advise the Secretary regarding—

''(i) the development, implementation, and updating of the scoring and ranking systems under sections 1860C–2(e) and 1881(b)(14)(E);

''(ii) the determination of the applicable percent for national performance quality payments under sections 1860C–2(c) and 1881(b)(14)(C);

''(iii) the selection of recipients of innovative quality practice awards under the program under section 5 of the Medicare Quality Improvement Act of 2004;

''(iv) the selection of demonstration project sites and the assessment of measures of quality of care under the demonstration program under section 6 of the Medicare Quality Improvement Act of 2004; and

''(v) the study and report under section 8(b) of the Medicare Quality Improvement Act of 2004.

''(B) ANNUAL REPORT ON INCENTIVE PROGRAMS.—The Board shall submit an annual report to the Secretary and Congress on the programs under sections 1860C–2 and 1881(b)(14).

''(C) ADDITIONAL DUTIES.—The Board shall perform such additional functions to assist the Secretary in carrying out the programs described in clauses (ii) and (iii) of subparagraph (A) and in subparagraph (B) as the Secretary may specify.

''(2) DEVELOPMENT AND ASSESSMENT OF NATIONAL PRIORITIES AND AGENDA.—The Board shall develop and assess national priorities and an agenda for improving the quality of items and services furnished to individuals entitled to benefits under this title.

''(d) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Board notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).''.

SEC. 8. STUDIES AND REPORTS ON FINANCIAL INCENTIVES FOR QUALITY ITEMS AND SERVICES UNDER THE MEDICARE PROGRAM.

(a) IOM STUDY AND REPORT ON HOW MEDICARE PAYMENTS FOR ITEMS AND SERVICES AFFECT THE QUALITY OF SUCH ITEMS AND SERVICES.—

(1) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on how the payment mechanisms for items and services under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act effect the quality of such items and services.

(2) REPORT TO CONGRESS.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(b) HHS STUDY AND REPORT ON PROVIDING FINANCIAL INCENTIVES FOR QUALITY SERVICES UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the actions necessary to establish a payment system under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act that aligns the quality of services provided under such program with the reimbursement provided under such program for such services.

(2) REPORT.—

(A) IN GENERAL.—Not later than January 1, 2008, the Secretary shall submit a report to Congress on the study conducted under paragraph (1).

(B) CONTENTS.—The report submitted under subparagraph (A) shall contain recommendations with respect to—

(i) the incremental steps necessary to develop the payment system described in paragraph (1);

(ii) the performance measures to be used under such payment system;

(iii) the incentive approaches to be used under such payment system;

(iv) the geographic and risk adjusters to be used under such payment system; and

(v) a strategy for aligning payment with performance across all parts of the medicare program.

(3) REQUIREMENT.—In conducting the study under paragraph (1) and preparing the report under paragraph (2), the Secretary shall—

(A) consult with the Quality Advisory Board established under section 1898 of the Social Security Act, as added by section 7; and

(B) take into account the report on health care performance measures submitted by the Institute of Medicine of the National Academy of Sciences under section 238 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213).

SEC. 9. MEDPAC STUDY AND REPORT ON USE OF ADJUSTER MECHANISMS UNDER MEDICARE QUALITY PERFORMANCE INCENTIVE PAYMENT PROGRAMS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study—

(1) to determine whether it is appropriate to incorporate a geographic adjuster into the quality performance incentive payment programs under sections 1860C–2 and 1881(b)(14) of the Social Security Act, as added by sections 3 and 4, respectively, to account for different environments of care, regional payment variation, regional variation of patient satisfaction, and regional case mix variation; and

(2) on the most appropriate methods to risk adjust data used under the scoring and ranking system under such programs pursuant to sections 1860C–2(e)(4) and 1881(b)(14)(E)(iv) of the Social Security Act.

(b) REPORT.—Not later than January 1, 2006, the Commission shall submit a report to Congress and the Secretary of Health and Human Services on the study conducted under subsection (a) together with recommendations for such legislation and administrative actions as the Commission considers appropriate. If such study concludes that a geographic adjuster described in subsection (a)(1) is appropriate, the Commission shall include in the report recommendations on how such adjuster could be incorporated into the quality performance incentive payment programs described in such subsection.

SEC. 10. DEMONSTRATION PROGRAM ON MEASURING THE QUALITY OF HEALTH CARE FURNISHED TO PEDIATRIC PATIENTS UNDER THE MEDICAID AND SCHIP PROGRAMS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a 3-year demonstration program to examine the development and use of quality measures, pay-for-performance programs, and other strategies in order to encourage providers to furnish superior quality health care to individuals under 18 years of age under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and under the SCHIP program under title XXI of such Act (42 U.S.C. 1397aa et seq.).

(2) AUTHORITY.—The Secretary shall conduct the demonstration program under this section pursuant to the authority provided under this section and not under the authority provided under section 1115 of the Social Security Act (42 U.S.C. 1315).

(b) SITES TO INCLUDE MULTIPLE SETTINGS AND PROVIDERS.—In selecting the demonstration program sites under this section, the Secretary shall ensure that the sites include health care delivery in multiple settings and through multiple providers, such as school-based settings and mental health providers.

(c) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI, XIX, and XXI of the Social Security Act (42 U.S.C. 1301 et seq.; 1396 et seq.; 1397aa et seq.) as may be necessary to carry out the purposes of the demonstration program under this section.

(d) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), for purposes of conducting the demonstration program under this section, expenditures under the demonstration program shall be treated as medical assistance under section 1903 of the Social Security Act (42 U.S.C. 1396) or child health assistance under section 2105 of such Act (42 U.S.C. 1397).

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures made by the Secretary do not exceed the amount which the Secretary would have expended if the demonstration program under this section had not been implemented.

(e) REPORT.—Not later than 6 months after the date on which the demonstration program under this section ends, the Secretary shall submit to Congress a report on the demonstration program together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

SEC. 11. PROVISIONS RELATING TO MEDICAID QUALITY IMPROVEMENTS.

(a) AUTHORIZATION FOR ADDITIONAL STAFF AT THE CENTER FOR MEDICAID AND STATE OPERATIONS.—

(1) ADDITIONAL STAFF.—The Secretary of Health and Human Services shall have the authority to hire 5 full-time employees to be employed within the Center for Medicaid and State Operations within the Centers for Medicare & Medicaid Services from among individuals who have experience with, or have been trained as, health professionals and who have experience in any of the following areas:

(A) Quality improvement.

(B) Chronic care management.

(C) Care coordination.

(2) REQUIREMENT FOE EXPERIENCE WITH PEDIATRIC POPULATIONS.—At least 1 of the individuals employed within the Center for Medicaid and State Operations pursuant to paragraph (1) shall have experience with pediatric populations.

(3) DUTIES OF ADDITIONAL STAFF.—The employees hired under paragraph (1) shall be responsible for developing strategies to access and promote quality improvement, chronic care management, and care coordination with the medicaid program and for providing technical assistance to the States.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection.

(b) CMS STUDY AND REPORT ON MEDICARE AND MEDICAID DATA COORDINATION.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify—

(A) efforts to coordinate and integrate data from the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act;

(B) barriers to data coordination;

(C) the potential benefits of data integration as perceived by medicare and medicaid program officials, policymakers, health care providers, and beneficiaries; and

(D) steps necessary to coordinate and integrate the beneficiary data from the medicare and medicaid programs.

(2) REPORT TO CONGRESS.—Not later than December 31, 2004, the Secretary of Health and Human Services shall submit to Congress a report on the results of the study conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(c) MEDPAC STUDY AND REPORT ON BENEFICIARIES WHO ARE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study to determine the characteristics of individuals who are eligible to receive benefits under both the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act, respectively, identify the costliest groups of individuals who are eligible for benefits under both programs, identify the services used by such individuals, and develop recommendations on how the provision of those services could be better coordinated for improved health outcomes and reduced costs.

(2) REPORT.—Not later than June 30, 2005, the Commission shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

(d) MEDPAC STUDY AND REPORT ON CARE COORDINATION PROGRAMS FOR DUAL-ELIGIBLES.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on care coordination programs available to individuals who are eligible to receive benefits under both the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act, respectively, the impact of such care coordination programs on those individuals, the impact of such care coordination programs on the costs of the medicare and medicaid programs to the Federal Government, and whether any savings from care coordination programs are counted as a benefit to either program.

(2) REPORT.—Not later than June 30, 2005, the Commission shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

SEC. 12. DEMONSTRATION PROGRAM FOR MEDICAL SMART CARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a 5-year demonstration program under which the Secretary shall award grants for the establishment of demonstration projects to provide for the development and use of Medical Smart Cards and to examine the impact of Medical Smart Cards on health care costs, quality of care, and patient safety.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall be a public or private nonprofit entity.

(c) APPLICATION.—An eligible entity desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

(d) APPROVAL OF APPLICATIONS.—

(1) IN GENERAL.—The Secretary shall approve applications for grants under this section in accordance with criteria established by the Secretary.

(2) LIMITATION.—The Secretary shall approve at least 1 application for a demonstration project that is conducted at a hospital or hospital system with a large rural service area.

(e) USE OF FUNDS.—An eligible entity shall use amounts received under a grant under this section to carry out the purposes described in subsection (a).

(f) REPORT.—Not later than 6 months after the date on which the demonstration program established under subsection (a) ends, the Secretary shall submit to Congress a report on the demonstration program together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

By Mr. KOHL (for himself and Mr. HATCH):

S. 2563. A bill to require imported explosives to be marked in the same manner as domestically manufactured explosives; to the Committee on the Judiciary.

Mr. KOHL. Mr. President, I rise today with Senator HATCH to introduce the Imported Explosives Security Act. Domestic manufacturers are required to place identification markings on all explosive materials they produce for important security reasons. These markings enable law enforcement officers to determine the source of explosives and help them solve crimes. Yet, these same identifying markings are not required of those explosives manufactured overseas and imported into our country. This impedes law enforcement efforts and poses a security risk.

The legislation we have introduced today is simple and straightforward. The legislation would simply treat imported explosives just like those manufactured inside the United States, requiring all imported explosives to carry the same markings currently placed on domestic explosives. It would require the name of the manufacturer, along with the time, date and shift of manufacture, to be placed on all explosives materials, whether they are manufactured here or abroad. These markings can be a tremendously useful tool for law enforcement officials, enabling investigators to determine the source of explosive materials. According to the Bureau of Alcohol, Tobacco, Firearms and Explosives, the explosives can then be tracked through records kept by those who manufacture and sell them, often leading them to the criminal who has stolen or misused them. At a recent Senate hearing, FBI Director Mueller acknowledged that ''determining the source of the components to any explosive device will assist you in determining who was responsible for any act using such a device.''

The Bureau of Alcohol, Tobacco, Firearms and Explosives first sought to fill this gap in the law when it published a notice of a proposed rulemaking in November 2000. Now, nearly 4 years later, this rulemaking still has not been finalized. Each year, more than 25,000 pounds of stolen, lost, or abandoned explosives are recovered by law enforcement. When explosives do not carry appropriate markings, they

cannot be quickly and effectively traced for criminal enforcement purposes.

Millions of pounds of unmarked explosives have already been distributed in this country. Each day we delay closing this loophole, we let more untraceable explosive materials cross our borders and undermine our national security. Failure to address this very straightforward issue in a timely manner unnecessarily hinders law enforcement's ability to solve crimes. Because the Department of Justice has not issued regulations to close this loophole in a timely manner, it is now incumbent upon us to act for them.

By Mr. CRAPO (for himself, Mr. FITZGERALD, Mr. LUGAR, Mr. SMITH, Mr. WYDEN, Mr. CRAIG, and Mr. ROBERTS):

S. 2565. A bill to amend the Agriculture Adjustment Act to convert the dairy forward pricing program into a permanent program of the Department of Agriculture; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. CRAPO. Mr. President, I rise to introduce the Milk Forward Contracting Act, a bill to make permanent the dairy forward pricing pilot program.

Without question, dairy producers are subject to a very fickle dairy market. Dairy prices can go from all time highs to all time lows over a course of a year, making long-term planning extremely difficult. This legislation will ensure the continued availability of an important risk management tool for dairy producers and enable their long-term business planning.

Over the pat 4 years, dairy producers and processors have been able to voluntarily enter into agreements for the sale of a specific volume of milk for a set price over an established period of time trough the dairy forward pricing pilot program. Many producers in my home State of Idaho and nationwide have used this voluntary program to reduce marketing risk by securing stable prices. Unfortunately, this program expires in December of 2004, and dairy producers want to be able to continue to utilize this program.

Forward contracting is a very useful tool for dairy farmers. In fact, a 2002 U.S. Department of Agriculture USDA report to Congress demonstrated that the program has been effective in reducing price volatility. According to USDA data for the September 2000 through December 2002 period, contracted milk averages $14.06 per hundredweight with a range of $1.63 between high and low prices, while non-contracted milk averaged $13.68 per hundredweight with a range of $6.69. Additionally, the U.S. General Accounting Office GAO reported that forward contracting is a risk management tool most frequently used by producers of other farm commodities.

Likewise, dairy producers should also have access to this important tool. There is no reason that dairy farmers should be forced to ride a dairy price roller coaster, when the extension of this sensible program would provide farm families with an option to help plan for their futures.

By Mr. BINGAMAN (for himself, Mr. CORZINE, Mr. LAUTENBERG, Ms. STABENOW, Mrs. CLINTON, Mr. JOHNSON, Ms. MIKULSKI, Mr. DURBIN, and Mr. DAYTON):

S. 2566. A bill to amend title II of the Social Security Act to phase out the 24-month waiting period for disabled individuals to become eligible for medicare benefits, to eliminate the waiting period for individuals with life-threatening conditions, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today to introduce legislation entitled ''Ending the Medicare Disability Waiting Period Act of 2004'' with Senators CORZINE, LAUTENBERG, STABENOW, CLINTON, JOHNSON, MIKULSKI, DURBIN, and DAYTON. This legislation would phase-out the current 2-year waiting period that people with disabilities must endure after qualifying for Social Security Disability Insurance (SSDI). In the interim, the bill would also create a process by which the Secretary can immediately waive the waiting period for people with life-threatening illnesses.

When Medicare was expanded in 1972 to include people with significant disabilities, lawmakers created the 24-month waiting period. According to a July 2003 report from the Commonwealth Fund, it is estimated that over 1.2 million SSDI beneficiaries are in the Medicare waiting period at any given time, ''all of whom are unable to work because of their disability and most of whom have serious health problems, low incomes, and limited access to health insurance.''

As Karen Davis, president of the Commonwealth Fund, said of the report, ''Individuals in the waiting period for Medicare suffer from a broad range of debilitating diseases and are in urgent need of appropriate medical care to manage their conditions. Eliminating the 2-year wait would ensure access to care for those already on the way to Medicare.''

These are people who are the most seriously disabled in our society and most in need of immediate health services. And yet, it is estimated that one-third of the 1.2 million currently federal policy puts the disabled on hold for 2 long years. The consequences are unacceptable and are, in fact, dire.

In fact, various studies show that death rates among SSDI recipients are highest during the first two years of enrollment. For example, the Commonwealth Fund report, entitled Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs, 4 percent of these people die during the waiting period. Of the estimated 400,000 uninsured disabled Americans in the waiting period at any given time, 16,000 of them will die awaiting Medicare coverage. This is unacceptable.

Moreover, this does not factor in the serious health problems that others experience while waiting for Medicare coverage during the 2-year period. Although there is no direct data on the profile of SSDI beneficiaries in the 2-year waiting period, the Commonwealth Fund has undertaken a separate analysis of the Medicare Current Beneficiary Survey for 1998 to get a good sense of the demographic characteristics, income, and health conditions of this group.

According to the analysis, ''. . . 45 percent of nonelderly Medicare beneficiaries with disabilities had incomes below the federal poverty line, and 77 percent had incomes below 200 percent of poverty. Fifth-nine percent reported that they were in fair or poor health; of this group, more than 90 percent reported that they suffered from one or more chronic illnesses, including arthritis (52%), hypertension (46%), mental disorder (36%), heart condition (35%), chronic lung disease (26%), cancer (20%), diabetes (19%), and stroke (12%).''

As the Medicare Rights Center has said, ''By forcing Americans with disabilities to wait 24 months for Medicare coverage, the current law effectively sentences these people to inadequate health care, poverty, or death . . . Since disability can strike anyone, at any point in life, the 24-month waiting period should be of concern to everyone, not just the millions of Americans with disabilities today.''

Although elimination of the Medicare waiting period will certainly increase Medicare costs, it is important to note that there will be some corresponding decrease in Medicaid costs. Medicaid, which is financed by both federal and state governments, often provides coverage for a subset of disabled Americans in the waiting period, as long as they meet certain income and asset limits. Income limits are typically at or below the poverty level, including at just 74 percent of the poverty line in New Mexico, with assets generally limited to just $2,000 for individuals and $3,000 for couples.

The Commonwealth Fund estimates that, of the 1.26 million people in the waiting period, 40 percent are enrolled in Medicaid. As a result, the Commonwealth Fund estimates that federal Medicaid savings would offset nearly 30 percent of the increased costs in its study. Furthermore, states, which have been struggling financially with their Medicaid programs, would reap a windfall that would help them better manage their Medicaid programs.

Furthermore, from a continuity of care point of view, it makes little sense that somebody with disabilities must leave their job and their health providers associated with that plan, move on the Medicaid to often have a different set of providers, to then switch to Medicare and yet another set of providers.

And finally, private-sector employers and employees in those risk-pools

would also benefit from the passage of the bill. As the report notes, ''. . . to the extent that disabled adults rely on coverage through their prior employer or their spouse's employer, eliminating the waiting period would also produce savings to employers who provide this coverage.''

I urge passage of this legislation and ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2566

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Ending the Medicare Disability Waiting Period Act of 2004''.

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

SEC. 2. PHASE OUT OF WAITING PERIOD FOR MEDICARE DISABILITY BENEFITS.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(1) in paragraph (2)(A), by striking '', and has for 24 calendar months been entitled to,'' and inserting '', and for the waiting period (as defined in subsection (k)) has been entitled to,'';

(2) in paragraph (2)(B), by striking '', and has been for not less than 24 months,'' and inserting '', and has been for the waiting period (as defined in subsection (k)),'';

(3) in paragraph (2)(C)(ii), by striking '', including the requirement that he has been entitled to the specified benefits for 24 months,'' and inserting '', including the requirement that the individual has been entitled to the specified benefits for the waiting period (as defined in subsection (k)),''; and

(4) in the flush matter following paragraph (2)(C)(ii)(II)—

(A) in the first sentence, by striking ''for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and'' and inserting ''for each month beginning after the waiting period (as so defined) for which the individual satisfies paragraph (2) and'';

(B) in the second sentence, by striking ''the 'twenty-fifth month of his entitlement' refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and''; and

(C) in the third sentence, by striking '', but not in excess of 78 such months''.

(b) SCHEDULE FOR PHASE OUT OF WAITING PERIOD.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended by adding at the end the following new subsection:

''(k) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974), the term 'waiting period' means—

''(1) for 2005, 18 months;
''(2) for 2006, 16 months;
''(3) for 2007, 14 months;
''(4) for 2008, 12 months;
''(5) for 2009, 10 months;
''(6) for 2010, 8 months;
''(7) for 2011, 6 months;
''(8) for 2012, 4 months;
''(9) for 2013, 2 months; and
''(10) for 2014 and each subsequent year, 0 months.''.

(c) CONFORMING AMENDMENTS.—

(1) SUNSET.—Effective January 1, 2014, subsection (f) of section 226 of the Social Security Act (42 U.S.C. 426) is repealed.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of such Act (42 U.S.C. 1395c(2)) is amended by striking ''entitled for not less than 24 months'' and inserting ''entitled for the waiting period (as defined in section 226(k))''.

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of such Act (42 U.S.C. 1395p(g)(1)) is amended by striking ''of the later of (A) April 1973 or (B) the third month before the 25th month of such entitlement'' and inserting ''of the third month before the first month following the waiting period (as defined in section 226(k)) applicable under section 226(b)''.

(4) RAILROAD RETIREMENT SYSTEM.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(A) by striking '', for not less than 24 months'' and inserting '', for the waiting period (as defined in section 226(k) of the Social Security Act); and

(B) by striking ''could have been entitled for 24 calendar months, and'' and inserting ''could have been entitled for the waiting period (as defined is section 226(k) of the Social Security Act), and''.

(d) EFFECTIVE DATE.—Except as provided in subsection (c)(1), the amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning at least 90 days after the date of the enactment of this Act.

SEC. 3. ELIMINATION OF WAITING PERIOD FOR INDIVIDUALS WITH LIFE-THREATENING CONDITIONS.

(a) IN GENERAL.—Section 226(h) of the Social Security Act (42 U.S.C. 426(h)) is amended—

(1) by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively;

(2) in the matter preceding subparagraph (A) (as redesignated by paragraph (1)), by inserting ''(1)'' after ''(h)'';

(3) in paragraph (1) (as designated by paragraph (2))—

(A) in the matter preceding subparagraph (A) (as redesignated by paragraph (1)), by inserting ''or any other life-threatening condition identified by the Secretary'' after ''amyotrophic lateral sclerosis (ALS)''; and

(4) in subparagraph (B) (as redesignated by paragraph (1)), by striking ''(rather than twenty-fifth month)''; and

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

''(2) For purposes of identifying life-threatening conditions under paragraph (1), the Secretary shall compile a list of conditions that are fatal without medical treatment. In compiling such list, the Secretary shall consult with the Director of the National Institutes of Health (including the Office of Rare Diseases), the Director of the Centers for Disease Control and Prevention, the Director of the National Science Foundation, and the Institute of Medicine of the National Academy of Sciences.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning at least 90 days after the date of the enactment of this Act.

SEC. 4. INSTITUTE OF MEDICINE STUDY AND REPORT ON DELAY AND PREVENTION OF DISABILITY CONDITIONS.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall request that the Institute of Medicine of the National Academy of Sciences conduct a study on the range of disability conditions that can be delayed or prevented if individuals receive access to health care services and coverage before the condition reaches disability levels.

(b) REPORT.—Not later than the date that is 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the Institute of Medicine study authorized under this section.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $750,000 for the period of fiscal years 2005 and 2006.

By Mrs. FEINSTEIN:

S. 2567. A bill to adjust the boundary of Redwood National Park in the State of California; to the Committee on Energy and Natural Resources.

Mrs. FEINSTEIN. Mr. President, I am pleased to introduce companion legislation to H.R. 3638, a bill introduced by Congressman MIKE THOMPSON in November 2003. This bill will adjust the boundary of Redwood National Park in the State of California to include the addition of the Mill Creek property.

In 2002, the California Department of Parks and Recreation acquired from the Save-the-Redwoods League 25,500 acres of forest land known as the Mill Creek property in Del Norte County, which is contiguous with the Redwood National and State parks boundary. This bill would include within the park boundary the Mill Creek acquisition and about 900 acres of land acquired and added to the State redwood parks since the 1978 expansion of the Redwood National Park boundary. There would be no Federal costs for land acquisition or development resulting from this legislation.

These lands will be managed by the same cooperative management agreement between the National Park Service and the California Department of Parks and Recreation. This partnership is viewed as a model of interagency cooperative management efforts and will provide for more efficient and cost-effective management of an ecologically significant resource.

This bill enjoys strong support from local and Federal officials, including Del Norte County and the Department of the Interior. Given this support and lack of controversy, I believe introducing companion legislation to be of great importance to ensure that our Redwood National Park is further protected.

I have long held a deep interest in protecting California's magnificent Redwoods. The Headwaters Agreement that was negotiated in part in my offices in 1996 protected approximately 7,500 acres of old growth redwoods, which was the largest grove of redwoods held in private ownership at the time.

I applaud Congressman MIKE THOMPSON's commitment to this issue and hope that this bill receives strong bipartisan support.

I urge my colleagues to support this legislation.

By Mr. BIDEN:

S. 2568. A bill to require the Secretary of the Treasury to mint coins in commemoration of the tercentenary of the birth of Benjamin Franklin, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. BIDEN. Mr. President, I rise today to introduce the Benjamin Franklin Commemorative Coin Act. This bill will authorize the U.S. Mint to produce a limited edition silver coin, in two designs, to honor the achievements of Benjamin Franklin, America's distinguished scientist, statesman, inventor and diplomat.

In 2006, the United States will host a worldwide celebration marking the 300th anniversary of Franklin's birth on January 17, 1706. Activities, lectures and exhibits are being developed through the efforts of the Benjamin Franklin Tercentenary Commission, as ordered by the Benjamin Franklin Tercentenary Commission Act, Public Law 107–202. The Commission, on which I serve with other elected officials and private sector partners, is responsible for providing a proper tribute to one of our most remarkable founding fathers. Surcharges on the sale of the coin would help the commission pay for activities it plans for celebrating Benjamin Franklin's birthday.

During the American Revolution, Franklin designed the first American coin—the ''Continental'' penny—and, until 1979, he was the only non-President of the United States whose image graced circulating coin and paper currency. it is only fitting that we honor Franklin's legacy through issuance of a commemorative coin.

This bill is the Senate companion to H.R. 3024, which was introduced by my colleague from Delaware, Congressman MIKE CASTLE, and it presently enjoys 326 cosponsors. As celebrations for our great leader are planned, I hope that my colleagues will join me in supporting a commemorative coin for this important American. I ask unanimous consent that the text of this bill be printed in the RECORD.

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

S. 2568

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Benjamin Franklin Commemorative Coin Act''.

SEC. 2. FINDINGS.

Congress finds that—

(1) Benjamin Franklin made historic contributions to the development of our Nation in a number of fields, including government, business, science, communications, and the arts;

(2) Benjamin Franklin was the only Founding Father to sign all of our Nation's organizational documents;

(3) Benjamin Franklin spent his career as a successful printer, which included printing the official currency for the colonies of Pennsylvania, Delaware, New Jersey and Maryland;

(4) Franklin's ''Essay on Paper Currency'' of 1741 proposed methods to fix the rate of exchange between the colonies and Great Britain;

(5) Benjamin Franklin, during the American Revolution, designed the first American coin, the ''Continental'' penny;

(6) Franklin made ''A Penny Saved is A Penny Earned'' a household phrase to describe the American virtues of hard work and economical living;

(7) Franklin played a major role in the design of the Great Seal of the United States, which appears on the $1 bill, and other major American symbols;

(8) Before 1979, Benjamin Franklin was the only non-president of the United States whose image graced circulating coin and paper currency;

(9) the official United States half dollar from 1948–1963 showed Franklin's portrait, as designed by John Sinnock;

(10) Franklin's ''Way to Wealth'' has come to symbolize America's commitment to free enterprise;

(11) the Franklin Institute Science Museum in Philadelphia (in this Act referred to as the ''Franklin Institute'') is a museum with an interactive approach to science and technology dedicated to the work of Benjamin Franklin;

(12) the Franklin Institute houses the first steam printing machine for coinage used by the United States Mint, which was placed in service in 1836, the 130th anniversary year of Franklin's birth;

(13) in 1976, Franklin Hall in the Franklin Institute was named the Official National Monument to the great patriot, scientist, and inventor;

(14) the Franklin Institute and 4 other major Benjamin Franklin-related Philadelphia cultural institutions joined hands in 2000 to organize international programs to commemorate the forthcoming 300th anniversary of Franklin's birth in 2006; and

(15) in 2002, Congress passed the Benjamin Franklin Tercentenary Commission Act (Public Law 107–202), creating a panel of distinguished Americans to work with the private sector in recommending appropriate Tercentenary programs, with the Franklin Institute serving as its administrative secretariat.

SEC. 3. COIN SPECIFICATIONS.

(a) DENOMINATIONS.—The Secretary of the Treasury (in this Act referred to as the ''Secretary'') shall mint and issue the following coins:

(1) $1 SILVER COINS WITH YOUNGER FRANKLIN IMAGE ON OBVERSE.—Not more than 250,000 $1 coins bearing the designs specified in section 4(a)(2), each of which shall—

(A) weigh 26.73 grams;

(B) have a diameter of 1.500 inches; and

(C) contain 90 percent silver and 10 percent copper.

(2) $1 SILVER COINS WITH OLDER FRANKLIN IMAGE ON OBVERSE.—Not more than 250,000 $1 coins bearing the designs specified in section 4(a)(3), each of which shall—

(A) weigh 26.73 grams;

(B) have a diameter of 1.500 inches; and

(C) contain 90 percent silver and 10 percent copper.

(b) LEGAL TENDER.—The coins minted under this Act shall be legal tender, as provided in section 5103 of title 31, United States Code.

(c) NUMISMATIC ITEMS.—For purposes of section 5136 of title 31, United States Code, all coins minted under this Act shall be considered to be numismatic items.

(d) USE OF THE UNITED STATES MINT AT PHILADELPHIA, PENNSYLVANIA.—It is the sense of the Congress that the coins minted under this Act should be struck at the United States Mint at Philadelphia, Pennsylvania, to the greatest extent possible.

SEC. 4. DESIGN OF COINS.

(a) DESIGN REQUIREMENTS.—

(1) IN GENERAL.—The design of the coins minted under this Act shall be emblematic of the life and legacy of Benjamin Franklin.

(2) $1 COINS WITH YOUNGER FRANKLIN IMAGE.—

(A) OBVERSE.—The obverse of the coins minted under section 3(a)(1) shall bear the image of Benjamin Franklin as a young man.

(B) REVERSE.—The reverse of the coins minted under section 3(a)(1) shall bear an image related to Benjamin Franklin's role as a patriot and a statesman.

(3) $1 COINS WITH OLDER FRANKLIN IMAGE.—

(A) OBVERSE.—The obverse of the coins minted under section 3(a)(2) shall bear the image of Benjamin Franklin as an older man.

(B) REVERSE.—The reverse of the coins minted under section 3(a)(2) shall bear an image related to Benjamin Franklin's role in developing the early coins and currency of the new country.

(4) DESIGNATION AND INSCRIPTIONS.—On each coin minted under this Act, there shall be—

(A) a designation of the value of the coin;

(B) an inscription of the year ''2006''; and

(C) inscriptions of the words ''Liberty'', ''In God We Trust'', ''United States of America'', and ''E Pluribus Unum''.

(b) SELECTION.—The design for the coins minted under this Act shall be—

(1) selected by the Secretary after consultation with the Commission of Fine Arts; and

(2) reviewed by the Citizens Coin Advisory Committee established under section 5135 of title 31, United States Code.

SEC. 5. ISSUANCE OF COINS.

(a) QUALITY OF COINS.—Coins minted under this Act shall be issued in uncirculated and proof qualities.

(b) COMMENCEMENT OF ISSUANCE.—The Secretary may issue coins minted under this Act beginning January 1, 2006, except that the Secretary may initiate sales of such coins, without issuance, before such date.

(c) TERMINATION OF MINTING AUTHORITY.—No coins shall be minted under this Act after December 31, 2006.

SEC. 6. SALE OF COINS.

(a) SALE PRICE.—Notwithstanding any other provision of law, the coins issued under this Act shall be sold by the Secretary at a price equal to the face value, plus the cost of designing and issuing such coins (including labor, materials, dies, use of machinery, overhead expenses, and marketing).

(b) BULK SALES.—The Secretary shall make bulk sales of the coins issued under this Act at a reasonable discount.

(c) PREPAID ORDERS AT A DISCOUNT.—

(1) IN GENERAL.—The Secretary shall accept prepaid orders for the coins minted under this Act before the issuance of such coins.

(2) DISCOUNT.—Sale prices with respect to prepaid orders under paragraph (1) shall be at a reasonable discount.

(d) SALES OF SINGLE COINS AND SETS OF COINS.—Coins of each design specified under section 4 may be sold separately or as a set containing a coin of each such design.

SEC. 7. SURCHARGES.

(a) SURCHARGE REQUIRED.—All sales of coins minted under this Act shall include a surcharge of $10 per coin.

(b) DISTRIBUTION.—Subject to section 5134(f) of title 31, United States Code, all surcharges which are received by the Secretary

from the sale of coins issued under this Act shall be promptly paid by the Secretary to the Franklin Institute, for purposes of the celebration of the Benjamin Franklin Tercentenary.

(c) AUDITS.—The Franklin Institute shall be subject to the audit requirements of section 5134(f)(2) of title 31, United States Code, for purposes of this Act.

By Ms. SNOWE:

S. 2569. A bill to amend section 227 of the Communications Act of 1934 to clarify the prohibition on junk fax transmissions; to the Committee on Commerce, Science, and Transportation.

Mr. SNOWE. Mr. President, I rise today to introduce the Junk Fax Prevention Act of 2004, a bill to strengthen our laws on protecting consumers and businesses from receiving unwanted commercial advertisements by facsimile, while at the same time preserving a key method of doing business for thousands of companies, large and small, across the United States. The sending of unsolicited commercial communications by facsimile—''junk faxes''—has been illegal since 1991, and the Federal Communications Commission is charged with enforcing that prohibition. Those who engage in ''blast faxes'' can and should be prosecuted to the full extent of the law, as their behavior imposes unreasonable expenses upon residential and business facsimile subscribers.

However, the FCC has long recognized an exception to this general ban on unsolicited faxes when the parties sending and receiving the fax have an established business relationship. Businesses of all shapes and sizes regularly conduct their transactions via facsimile, such as real estate agents, wholesalers and distributors, travel agents, and those in the convention industry. In our modern economy, companies that are often hundreds or thousands of miles away from each other do business together, often with the same or greater frequency as with those just up the street. And the reality of business is that sometimes you need to communicate in writing, and it needs to get there right away.

The established business relationship exemption recognized this reality, and ensured that government was not placing an undue hardship on business owners. Yet inexplicably, on June 26, 2003 the FCC issued a new rule that eliminated the established business relationship. Under this new rule—which is set to take effect on January 1, 2005—the sender of a fax would have to acquire, in writing, the permission of the recipient to receive an unsolicited fax before the fax could be sent, even if the recipient made a verbal request that the information be faxed.

As Chair of the Senate Small Business Committee, I can state that the business community has in unison called upon Congress to take action to rectify this situation. Industry groups estimate that it will cost businesses an average of $5,000 in the first year alone to comply with the new law, and as much as $3,000 each year thereafter in record-keeping costs. These numbers do not take into account the potential lost business that could easily result if a primary method of business-to-business communication is cut off. Quite simply, small businesses in particular will suffer significantly if these rules are allowed to take effect.

My bill will restore the established business relationship exemption, allowing standard business transactions to continue without inhibition. The term ''Established business relationship'' means the same thing in the Junk Fax Prevention Act as in the regulations governing the Federal Do-Not-Call Registry: it means that the fax subscriber either made an inquiry of the sender within the prior three months or a purchase from the sender within the prior 18 months.

The Junk Fax Prevention Act also strengthens the protections available to fax recipients by adding an opt-out provision that the current law does not have. Even if an established business relationship exists, a fax subscriber can still request to not receive unsolicited faxes. The senders of these faxes must, by law, honor these requests, and they must include a notification of this right on every fax they send.

As a strong supporter of consumer rights, I also want to assure my colleagues that this bill does not in any way place consumers at risk. Very few consumers own fax machines, and those who do are protected by the general ban on solicitation and the opt-out provision if they do have an existing business relationship. To ensure that the privacy of consumers and businesses is protected, my bill also provides for studies by both the General Accounting Office and the FCC to evaluate the effectiveness of enforcement.

Small businesses have weathered the storm of the economic downturn over the past several years. As our economy now climbs out of recession and people return back to work, American businesses—our nation's employers do not need these unnecessary economic restraints to further hinder their recovery. I call upon all of my colleagues to join me in bringing relief to American businesses and pass the Junk Fax Prevention Act.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2569

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Junk Fax Prevention Act of 2004''.

SEC. 2. PROHIBITION ON FAX TRANSMISSIONS CONTAINING UNSOLICITED ADVERTISEMENTS.

(a) PROHIBITION.—Subparagraph (C) of section 227(b)(1) of the Communications Act of 1934 (47 U.S.C. 227(b)(1)(C)) is amended to read as follows:

''(C) to use any telephone facsimile machine, computer, or other device to send, to a telephone facsimile machine, an unsolicited advertisement—

''(i) to a person who has made a request to such sender that complies with the requirements under paragraph (2)(D), not to send future unsolicited advertisements to a telephone facsimile machine; or

''(ii) to a person not described in clause (i), unless—

''(I) the sender has an established business relationship (which term, for purposes of this subclause, shall have the meaning given the term in section 64.1200 of the Commission's regulations, as in effect on January 1, 2003, except that such term shall apply to a business subscriber in the same manner in which it applies to a residential subscriber) with such person; and

''(II) the unsolicited advertisement contains a conspicuous notice on the first page of the unsolicited advertisement that—

''(aa) states that the recipient may make a request to the sender of the unsolicited advertisement not to send any future unsolicited advertisements to such telephone facsimile machine and that failure to comply, within the shortest reasonable time, as determined by the Commission, with such a request meeting the requirements under paragraph (2)(D) is unlawful;

''(bb) sets forth the requirements for a request under paragraph (2)(D); and

''(cc) includes a domestic contact telephone and facsimile number for the recipient to transmit such a request to the sender, neither of which may be a number for a pay-per-call service (as such term is defined in section 228(i)); any number supplied shall permit an individual or business to make a do-not-fax request during regular business hours; or''.

(b) REQUEST TO OPT-OUT OF FUTURE UNSOLICITED ADVERTISEMENTS.—Paragraph (2) of section 227(b) of the Communications Act of 1934 (47 U.S.C. 227(b)(2)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

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

''(D) shall provide, by rule, that a request not to send future unsolicited advertisements to a telephone facsimile machine complies with the requirements under this subparagraph only if—

''(i) the request identifies the telephone number of the telephone facsimile machine to which the request relates;

''(ii) the request is made to the telephone or facsimile number of the sender of such an unsolicited advertisement provided pursuant to paragraph (1)(C)(ii)(II)(cc) or by any other method of communication as determined by the Commission; and

''(iii) the person making the request has not, subsequent to such request, provided express invitation or permission to the sender, in writing or otherwise, to send such advertisements to such person at such telephone facsimile machine; and

''(E) may, in the discretion of the Commission and subject to such conditions as the Commission may prescribe, allow professional trade associations that are tax-exempt nonprofit organizations to send unsolicited advertisements to their members in furtherance of the association's tax-exempt purpose that do not contain the notice required by paragraph (1)(C)(ii)(II), except that the Commission may take action under this subparagraph only by regulation issued after notice and opportunity for public comment

in accordance with section 553 of title 5, United States Code, and only if the Commission determines that such notice is not necessary to protect the right of the members of such trade associations to make a request to their trade associations not to send any future unsolicited advertisements.''.

(c) UNSOLICITED ADVERTISEMENT.—Paragraph (4) of section 227(a) of the Communications Act of 1934 (47 U.S.C. 227(a)(4)) is amended by inserting '', in writing or otherwise'' before the period at the end.

(d) REGULATIONS.—Not later than 270 days after the date of the enactment of this Act, the Federal Communications Commission shall issue regulations to implement the amendments made by this section.

SEC. 3. FCC ANNUAL REPORT REGARDING JUNK FAX ENFORCEMENT.

Section 227 of the Communications Act of 1934 (47 U. S.C. 227) is amended by adding at the end the following new subsection:

''(g) JUNK FAX ENFORCEMENT REPORT.—The Commission shall submit a report to the Congress for each year regarding the enforcement of the provisions of this section relating to sending of unsolicited advertisements to telephone facsimile machines, which shall include the following information:

''(1) The number of complaints received by the Commission during such year alleging that a consumer received an unsolicited advertisement via telephone facsimile machine in violation of the Commission's rules.

''(2) The number of such complaints received during the year on which the Commission has taken action.

''(3) The number of such complaints that remain pending at the end of the year.

''(4) The number of citations issued by the Commission pursuant to section 503 during the year to enforce any law, regulation, or policy relating to sending of unsolicited advertisements to telephone facsimile machines.

''(5) The number of notices of apparent liability issued by the Commission pursuant to section 503 during the year to enforce any law, regulation, or policy relating to sending of unsolicited advertisements to telephone facsimile machines.

''(6) For each such notice—

''(A) the amount of the proposed forfeiture penalty involved;

''(B) the person to whom the notice was issued;

''(C) the length of time between the date on which the complaint was filed and the date on which the notice was issued; and

''(D) the status of the proceeding.

''(7) The number of final orders imposing forfeiture penalties issued pursuant to section 503 during the year to enforce any law, regulation, or policy relating to sending of unsolicited advertisements to telephone facsimile machines.

''(8) For each such forfeiture order—

''(A) the amount of the penalty imposed by the order;

''(B) the person to whom the order was issued;

''(C) whether the forfeiture penalty has been paid; and

''(D) the amount paid.

''(9) For each case in which a person has failed to pay a forfeiture penalty imposed by such a final order, whether the Commission referred such matter to the Attorney General for recovery of the penalty.

''(10) For each case in which the Commission referred such an order to the Attorney General—

''(A) the number of days from the date the Commission issued such order to the date of such referral;

''(B) whether the Attorney General has commenced an action to recover the penalty, and if so, the number of days from the date the Commission referred such order to the Attorney General to the date of such commencement; and

''(C) whether the recovery action resulted in collection of any amount, and if so, the amount collected.''.

SEC. 4. GAO STUDY OF JUNK FAX ENFORCEMENT.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study regarding complaints received by the Federal Communications Commission concerning unsolicited advertisements sent to telephone facsimile machines, which shall determine—

(1) the number and nature of such complaints;

(2) the number of such complaints that result in final agency actions by the Commission;

(3) the length of time taken by the Commission in responding to such complaints;

(4) the mechanisms established by the Commission to receive, investigate, and respond to such complaints;

(5) the level of enforcement success achieved by the Commission and the Attorney General regarding such complaints;

(6) whether complainants to the Commission are adequately informed by the Commission of the responses to their complaints; and

(7) whether additional enforcement measures are necessary to protect consumers, including recommendations regarding such additional enforcement measures.

(b) ADDITIONAL ENFORCEMENT REMEDIES.—In conducting the analysis and making the recommendations required under paragraph (7) of subsection (a), the Comptroller General shall specifically examine—

(1) the adequacy of existing statutory enforcement actions available to the Commission;

(2) the adequacy of existing statutory enforcement actions and remedies available to consumers;

(3) the impact of existing statutory enforcement remedies on senders of facsimiles;

(4) whether increasing the amount of financial penalties is warranted to achieve greater deterrent effect; and

(5) whether establishing penalties and enforcement actions for repeat violators or abusive violations similar to those established by section 4 of the CAN–SPAM Act of 2003 (15 U.S.C. 7703) would have a greater deterrent effect.

(c) REPORT.—Not later than 270 days after the date of the enactment of this Act, the Comptroller General shall submit a report on the results of the study under this section to Committee on Energy and Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 389—EXPRESSING THE SENSE OF THE SENATE WITH RESPECT TO PROSTATE CANCER INFORMATION

Mr. CAMPBELL (for himself, Mr. JOHNSON, Mr. BUNNING, Mr. CHAMBLISS, Mr. GRAHAM of South Carolina, Mr. BURNS, and Mrs. LINCOLN) submitted the following resolution; which was referred to the Committee on Health, Education, Labor and Pensions:

S. RES. 389

Whereas in 2004, it is estimated that approximately 230,000 new cases of prostate cancer will be diagnosed in the United States, and nearly 30,000 men in the United States will die from prostate cancer;

Whereas prostate cancer is the second leading cause of cancer death in men in the United States;

Whereas more than $4,700,000,000 is spent annually in the United States in direct treatment costs for prostate cancer;

Whereas African-American men are diagnosed with and die from prostate cancer more frequently than men of other ethnic backgrounds;

Whereas increased education among health care providers and patients regarding the need for prostate cancer screening tests has resulted in the diagnosis of approximately 86 percent of prostate cancer patients before the cancerous cells have spread appreciably beyond the prostate gland, thereby enhancing the odds of successful treatment;

Whereas the potential complication rates for significant side effects vary among the most common forms of treatment for prostate cancer;

Whereas prostate cancer often strikes elderly people in the United States, men should have an opportunity to learn about the benefits and limitations of testing for prostate cancer detection and of treatment of prostate cancer, so that they can make an informed decision with the assistance of a clinician; and

Whereas Congress as a whole, and Members of Congress as individuals, are in unique positions to support the fight against prostate cancer, to help raise public awareness about the need to make screening tests available to all people at risk for prostate cancer, and to provide prostate cancer patients with adequate information to assess the relative benefits and risks of treatment options: Now, therefore, be it

Resolved, That it is the sense of the Senate that—

(1) national and community organizations and health care providers have played a commendable role in supplying information concerning the importance of screening for prostate cancer and the treatment options for patients with prostate cancer; and

(2) the Federal Government and the States should ensure that health care providers supply prostate cancer patients with appropriate information and any other tools necessary for prostate cancer patients to receive readily understandable descriptions of the advantages, disadvantages, benefits, and risks of all medically efficacious screening and treatments for prostate cancer, including brachytherapy, hormonal treatments, external beam radiation, chemotherapy, surgery, and watchful waiting.

Mr. CAMPBELL. Mr. President, today I am pleased to be joined by my colleagues Senators JOHNSON, BUNNING, CHAMBLISS, LINDSEY GRAHAM, BURNS, and LINCOLN to submit legislation which would express the Sense of the Senate that physicians inform prostate cancer patients of all of their treatment options. The non-binding resolution which we are introducing stresses the importance of presenting all options to men diagnosed with prostate cancer.

Prostate cancer is the second leading cause of cancer death of men in this country and is particularly devastating for men over the age of 50. In 2004, it is estimated that approximately 230,000 new cases of prostate cancer will be diagnosed in the United States, and nearly 30,000 men will die from the disease. Clearly, the effort to raise public understanding about treatment options is crucial.