Hostettler	Miller, Gary	Sherwood
Houghton	Mollohan	Shimkus
Hulshof	Moran (KS)	Shuster
Hunter	Morella	Simpson
Hutchinson	Nethercutt	Skeen
Hyde	Ney	Smith (MI)
Isakson	Northup	Smith (NJ)
Istook	Norwood	Smith (TX)
Jenkins	Nussle	Souder
Johnson (CT)	Ose	Spence
Johnson, Sam	Oxley	Stearns
Jones (NC)	Packard	Stump
Kasich	Paul	Sununu
Kelly	Pease	Sweeney
Kind (WI)	Peterson (MN)	Talent
King (NY)	Peterson (PA)	Tancredo
Kingston	Petri	Tauzin
Kleczka	Phelps	Taylor (NC)
Klink	Pickering	Terry
Knollenberg	Pitts	Thomas
Kolbe	Porter	Thornberry
Kucinich	Portman	Thune
Kuykendall	Pryce (OH)	Thurman
LaHood	Quinn	Tiahrt
Largent	Rahall	Toomey
Larson	Ramstad	Towns
Latham	Regula	Traficant
LaTourette	Reynolds	Udall (NM)
Lazio	Riley	Upton
Leach	Roemer	Vitter
Lewis (CA)	Rogan	Walden
Lewis (KY)	Rogers	Walsh
Linder	Rohrabacher	Wamp
Lipinski	Ros-Lehtinen	Watkins
LoBiondo	Roukema	Watt (NC)
Lofgren	Royce	Watts (OK)
Lucas (OK)	Ryan (WI)	Weldon (FL)
Manzullo	Ryun (KS)	Weldon (PA)
Martinez	Salmon	Weller
McCollum	Sanford	Whitfield
McCrery	Saxton	Wicker
McHugh	Scarborough	Wilson
McInnis	Schaffer	Wise
McIntosh	Sensenbrenner	Wolf
McKeon	Sessions	Young (AK)
Metcalf	Shadegg	Young (FL)
Mica	Shaw	
Miller (FL)	Shays	

NOT VOTING—13

Cook	Maloney (NY)	Radanovich
Gilman	Markey	Strickland
Goodling	Myrick	Vento
Herger	Olver	
Maloney (CT)	Pombo	

□ 1428

So the motion to adjourn was rejected.

The result of the vote was announced as above recorded.

MEDICARE RX 2000 ACT

Mr. ARCHER. Mr. Speaker, pursuant to H. Res. 539, I call up the bill (H.R. 4680), to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. LAHOOD). Pursuant to House Resolution 539, the bill is considered read for amendment.

The text of the bill, H.R. 4680, is as follows:

H.R. 4680

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 ''Medicare Rx 2000 Act''.

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

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

''(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

''(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in the plan and obtain coverage through such plan.

''(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860C(a)).

Such individuals shall have a choice of such plans under section 1860E(d).

''(b) GENERAL ELECTION PROCEDURES.—

''(1) IN GENERAL.—An individual may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1807(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

''(2) ELECTION PERIODS.—

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

''(i) annual coordinated election periods; and

''(ii) special election periods.

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

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is enrolled under part B as of November 1, 2002, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first enrolled under part B after November 1, 2002, there

shall be an initial election period which is the same as the initial election period under section 1851(e)(1).

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

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C); and

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

''(D) ONE-TIME ENROLLMENT PERMITTED FOR CURRENT PART A ONLY BENEFICIARIES.—In the case of an individual who as of November 1, 2002—

''(i) is entitled to benefits under part A; and

''(ii) is not (and has not previously been) enrolled under part B;

the individual shall be eligible to enroll in a prescription drug plan under this part but only during the period described in subparagraph (B)(i). If the individual enrolls in such a plan, the individual may change such enrollment under this part, but the individual may not enroll in a Medicare+Choice plan under part C unless the individual enrolls under part B. Nothing in this subparagraph shall be construed as providing for coverage under a prescription drug plan of benefits that are excluded because of the application of section 1860B(f)(2)(B).

''(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

''(2) COMMUNITY-RATED PREMIUM.—

''(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since first qualifying to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

''(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage, a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) increase the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

''(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after a date if the individual establishes that there is no period of 63 days or longer on and after such date (beginning not earlier than January 1, 2003) during all of which the individual did not have any of the following prescription drug coverage:

''(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

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

''(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1).

''(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2003, and only until the date such coverage is terminated.

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

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

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

''(E) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

''(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(d) EFFECTIVE DATE OF ELECTIONS.—

''(1) IN GENERAL.—Except as provided in this section, the Medicare Benefits Administrator shall provide that elections under subsection (b) take effect at the same time as the Secretary provides that similar elections under section 1851(e) take effect under section 1851(f).

''(2) NO ELECTION EFFECTIVE BEFORE 2003.—In no case shall any election take effect before January 1, 2003.

''(3) TERMINATION.—The Medicare Benefits Administrator shall provide for the termination of elections in the case of—

''(A) termination of coverage under part B (other than the case of an individual described in subsection (b)(2)(D) (relating to part A only individuals); and

''(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

''SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENTS.—

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

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

''(B) DISAPPROVAL AUTHORITY.—The Medicare Benefits Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is purposefully engaged in activities intended to result in favorable selection of those eligible medicare beneficiaries obtaining coverage through the plan, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

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

''(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

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

''(A) for 2003, that is equal to $250; or

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

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

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

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

''(A) for 2003, that is equal to $2,100; or

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

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

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

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits without any cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(i) for 2003, is equal to $6,000; or

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

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

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

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); but

''(ii) costs shall be treated as incurred without regard to whether the individual or another person, including a State program, has paid for such costs, but shall not be counted insofar as such costs are covered as benefits under a prescription drug plan, a Medicare+Choice plan, or other third-party coverage.

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

''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b)(1) so long as the following requirements are met:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the reinsurance subsidy payments under section 1860H with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (b)(1) and the initial coverage limit under subsection (b)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (b)(2).

''(2) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES.—The coverage provides the limitation on out-of-pocket expenditures by beneficiaries described in subsection (b)(4).

''(d) ACCESS TO NEGOTIATED PRICES.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)).

''(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

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

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

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

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

''(B) for determining annual percentage increases described in subsection (b)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

''(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

''(B) a biological product or insulin described in subparagraph (B) or (C) of such section.

''(2) EXCLUSIONS.—

''(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents).

''(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B (but shall be so considered if such payment is not available because benefits under part A or B have been exhausted), without regard to whether the individual is entitled to benefits under part A or enrolled under part B.

''(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary that meets the requirements of section 1860C(f)(2) (including providing an appeal process).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

''SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) GUARANTEED ISSUE AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, and nondiscrimination, see sections 1860A(c) and 1860F(b).

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

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

''(B) How any formulary used by the sponsor functions.

''(C) Co-payments and deductible requirements.

''(D) Grievance and appeals procedures.

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

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ASSURING PHARMACY ACCESS.—The PDP sponsor of the prescription drug plan shall secure the participation of sufficient numbers of pharmacies (which may include mail order pharmacies) to ensure convenient access (including adequate emergency access) for enrolled beneficiaries. Nothing in this paragraph shall be construed as requiring the participation of all pharmacies in any area under a plan.

''(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—The PDP sponsor of a prescription drug plan shall issue such a card that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—Insofar as a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

''(A) FORMULARY COMMITTEE.—The sponsor must establish a pharmaceutical and therapeutic committee that develops the formulary. Such committee shall include at least one physician and at least one pharmacist.

''(B) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within all therapeutic categories and classes of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The PDP sponsor must have, as part of the appeals process under subsection (i)(2), a process for appeals for denials of coverage based on such application of the formulary.

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

''(1) IN GENERAL.—The PDP sponsor shall have in place—

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

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2); and

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

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

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

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

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

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

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

''(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

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

''(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

''(B) Subsection (c)(1) (relating to access to covered benefits).

''(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(e) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

''(f) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—A PDP sponsor shall meet the requirements of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) APPEALS OF FORMULARY DETERMINATIONS.—Under the appeals process under paragraph (1) an individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a medically necessary covered outpatient drug that is not on the formulary of the sponsor (established under subsection (c)) if the prescribing physician determines that the therapeutically similar drug that is on the formulary is not effective for the enrollee or has significant adverse effects for the enrollee.

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

''SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS.

''(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

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

''(2) ASSUMPTION OF FULL FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under reinsurance under section 1860H.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Medicare Benefits Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than 1 prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(2) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

''(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

''(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

''(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

''(i) such section shall be applied separately to costs relating to this part (from costs under part C);

''(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

''(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

''(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

''(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

''(3) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (2)(E)—

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

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

''(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

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

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

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

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

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

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

''(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

''(1) ESTABLISHMENT.—The Medicare Benefits Administrator shall establish, by not later than October 1, 2001, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

''(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State

under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Medicare Benefits Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) OTHER STANDARDS.—The Medicare Benefits Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2001. In order to carry out this requirement in a timely manner, the Administrator may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(f) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this subsection shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to prescription drug plans which are offered by PDP sponsors under this part to the extent such law or regulation is inconsistent with such standards, in the same manner as such laws and regulations are superseded under section 1856(b)(3).

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

''(A) Benefit requirements.

''(B) Requirements relating to inclusion or treatment of providers.

''(C) Coverage determinations (including related appeals and grievance processes).

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Medicare Benefits Administrator under this part.

''SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) IN GENERAL.—The Medicare Benefits Administrator, through the Office of Beneficiary Assistance, shall establish, based upon and consistent with the procedures used under part C (including section 1851), a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

''(b) ELEMENTS.—Such process shall include the following:

''(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

''(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-federal entities.

''(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

''(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

''(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall assure that each individual who is enrolled under part B and who is residing in an area has available a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least 1 of which is a prescription drug plan.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Medicare Benefits Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Medicare Benefits Administrator—

''(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

''(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

''(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

''(4) REPORTS.—The Medicare Benefits Administrator shall, in each annual report to Congress under section 1807(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

''(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a a Medicare+Choice plan that includes qualified prescription drug coverage.

''SEC. 1860F. PREMIUMS.

''(a) SUBMISSION OF PREMIUMS AND RELATED INFORMATION.—

''(1) IN GENERAL.—Each PDP sponsor shall submit to the Medicare Benefits Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

''(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

''(A) Information on the qualified prescription drug coverage to be provided.

''(B) Information on the actuarial value of the coverage.

''(C) Information on the monthly premium to be charged for the coverage, including an actuarial certification of—

''(i) the actuarial basis for such premium;

''(ii) the portion of such premium attributable to benefits in excess of standard coverage; and

''(iii) the reduction in such premium resulting from the reinsurance subsidy payments provided under section 1860H.

''(D) Such other information as the Medicare Benefits Administrator may require to carry out this part.

''(3) REVIEW.—The Medicare Benefits Administrator shall review the information filed under paragraph (2) and shall approve or disapprove such rates, amounts, and values so submitted. In exercising such authority, the Administrator shall take into account the reinsurance subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered and shall have the same authority to negotiate the terms and conditions of such premiums and other terms and conditions of plans as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code.

''(b) UNIFORM PREMIUM.—The premium for a prescription drug plan charged under this section may not vary among individuals enrolled in the plan in the same service area, except as is permitted under section 1860A(c)(2)(B) (relating to late enrollment penalties).

''(c) TERMS AND CONDITIONS FOR IMPOSING PREMIUMS.—The provisions of section 1854(d) shall apply under this part in the same manner as they apply under part C, and, for this purpose, the reference in such section to section 1851(g)(3)(B)(i) is deemed a reference to section 1860A(d)(3)(B) (relating to failure to pay premiums required under this part).

''(d) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

''(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the reference premium under section 1860G(b)(2) as payment in full for the premium charge for qualified prescription drug coverage.

''(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

''SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

''(a) IN GENERAL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

''(A) to a premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that are nominal.

''(2) SLIDING SCALE PREMIUM SUBSIDY FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to a premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

''(3) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

''(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

''(ii) has income below 150 percent of the Federal poverty line; and

''(iii) meets the resources requirement described in section 1905(p)(1)(C).

''(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Medicare Benefits Administrator.

''(C) INCOME DETERMINATIONS.—For purposes of applying this section—

''(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

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

''(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

''(b) PREMIUM SUBSIDY AMOUNT.—

''(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the reference premium (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

''(2) REFERENCE PREMIUM DEFINED.—For purposes of this subsection, the term 'reference premium' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the premium imposed for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a Medicare+Choice plan, the standard premium computed under section 1851(j)(4)(A)(iii), determined without regard to any reduction effected under section 1851(j)(4)(B).

''(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

''(1) IN GENERAL.—In applying subsection (a)(1)(B)—

''(A) the maximum amount of subsidy that may be provided with respect to an enrollee for a year may not exceed 95 percent of the maximum cost-sharing described in such subsection that may be incurred for standard coverage;

''(B) the Medicare Benefits Administrator shall determine what is 'nominal' taking into account the rules applied under section 1916(a)(3); and

''(C) nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor may not charge more than a nominal amount in cases in which the cost-sharing subsidy is provided under such subsection.

''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Medicare Benefits Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

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

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

''(e) RELATION TO MEDICAID PROGRAM.—

''(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES THROUGH REINSURANCE FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REINSURANCE SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Medicare Benefits Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

''(1) for individuals enrolled with a prescription drug plan under this part;

''(2) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

''(3) for medicare primary individuals (described in subsection (f)(3)(D)) who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) A PDP sponsor offering a prescription drug plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(2) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds $1,250, but does not exceed $1,350, an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

''(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,350, but does not exceed $1,450, an amount equal to 50 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(C) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,450, but does not exceed $1,550, an amount equal to 70 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(D) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,550, but does not exceed $2,350, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(E) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $7,050, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INDEXING DOLLAR AMOUNTS.—

''(A) AMOUNTS FOR 2003.—The dollar amounts applied under paragraph (1) for 2003 shall be the dollar amounts specified in such paragraph.

''(B) FOR 2004.—The dollar amounts applied under paragraph (1) for 2004 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2004.

''(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a

year after 2004 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) for the year involved.

''(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(d) ADJUSTMENT OF PAYMENTS.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall estimate—

''(A) the total payments to be made (without regard to this subsection) during a year under this section; and

''(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(2) ADJUSTMENT OF PAYMENTS.—The Administrator shall proportionally adjust the payments made under this section for a coverage year in such manner so that the total of the payments made for the year under this section is equal to 35 percent of the total payments described in paragraph (1)(B) during the year.

''(e) PAYMENT METHODS.—

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

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

''(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Medicare Benefits Administrator may require, that the coverage meets the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Medicare Benefits Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of payments made, and such other matters as may be appropriate.

''(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

''(D) OTHER REQUIREMENTS.—The sponsor of the plan shall comply with such other requirements as the Medicare Benefits Administrator finds necessary to administer the program under this section.

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is a medicare primary individual who—

''(A) is covered under the plan; and

''(B) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

''(3) DEFINITIONS.—As used in this section:

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for medicare primary individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

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

''(D) MEDICARE PRIMARY INDIVIDUAL.—The term 'medicare primary individual' means, with respect to a plan, an individual who is covered under the plan and with respect to whom the plan is not a primary plan (as defined in section 1862(b)(2)(A)).

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled with a prescription drug plan under this part;

''(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

''(C) is covered as a medicare primary individual under a qualified retiree prescription drug plan.

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

''SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.

''(a) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Medicare Prescription Drug Account' (in this section referred to as the 'Account'). The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Medicare Benefits Administrator certifies are necessary to make—

''(A) payments under section 1860G (relating to low-income subsidy payments);

''(B) payments under section 1860H (relating to reinsurance subsidy payments); and

''(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(c) DEPOSITS INTO ACCOUNT.—

''(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b), reduced by the amount transferred to the Account under paragraph (1).

''SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

''(a) DEFINITIONS.—For purposes of this part:

''(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

''(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(3) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term 'Medicare Prescription Drug Account' means the Account in the Federal Supplementary Medical Insurance Trust Fund created under section 1860I(a).

''(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

''(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

''(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Medicare Benefits Administrator and the sponsor under section 1860D(b);

''(B) provides qualified prescription drug coverage; and

''(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

''(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

''(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

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

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

(c) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts'', and

(B) by inserting before the period the following: ''and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860I''; and

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the

payments shall come from the Medicare Prescription Drug Account in the Trust Fund),''.

(d) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

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

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

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

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D. The Medicare Benefits Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) TREATMENT OF COVERAGE.—Except as provided in this subsection, qualified prescription drug coverage offered under this subsection shall be treated under this part in the same manner as supplemental health care benefits described in section 1852(a)(3)(A).

''(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

''(B) providing a Medicare+Choice organization with reinsurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

''(5) SPECIFICATION OF SEPARATE AND STANDARD PREMIUM.—

''(A) IN GENERAL.—For purposes of applying section 1854 and section 1860G(b)(2)(B) with respect to qualified prescription drug coverage offered under this subsection under a plan, the Medicare+Choice organization shall compute and publish the following:

''(i) SEPARATE PRESCRIPTION DRUG PREMIUM.—A premium for prescription drug benefits that constitute qualified prescription drug coverage that is separate from other coverage under the plan.

''(ii) PORTION OF COVERAGE ATTRIBUTABLE TO STANDARD BENEFITS.—The ratio of the actuarial value of standard coverage to the actuarial value of the qualified prescription drug coverage offered under the plan.

''(iii) PORTION OF PREMIUM ATTRIBUTABLE TO STANDARD BENEFITS.—A standard premium equal to the product of the premium described in clause (i) and the ratio under clause (ii).

The premium under clause (i) shall be compute without regard to any reduction in the premium permitted under subparagraph (B).

''(B) REDUCTION OF PREMIUMS ALLOWED.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from reducing the amount of a premium charged for prescription drug coverage because of the application of section 1854(f)(1)(A) to other coverage.

''(C) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—For requirement to accept reference premium as full premium if there is no standard (or equivalent) coverage in the area of a Medicare+Choice plan, see section 1860F(d).

''(6) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2003 shall be the 6-month period beginning with November 2002.

''(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860B.''.

(b) CONFORMING AMENDMENTS.—Section 1851 of such Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

''and may elect qualified prescription drug coverage in accordance with section 1860A.''; and

(2) in subsection (g)(1), by inserting ''and section 1860A(c)(2)(B)'' after ''in this subsection''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2003.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (64);

(ii) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(iii) by inserting after paragraph (65) the following new paragraph:

''(66) provide for making eligibility determinations under section 1935(a).''.

(2) NEW SECTION.—Title XIX of such Act is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

''(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows:

''(A) For expenditures attributable to costs incurred during 2003, the otherwise applicable Federal matching rate shall be increased by 20 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B) For expenditures attributable to costs incurred during 2004, the otherwise applicable Federal matching rate shall be increased by 40 percent of the percentage otherwise payable (but for this subsection) by the State.

''(C) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

''(D) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 80 percent of the percentage otherwise payable (but for this subsection) by the State.

''(E) For expenditures attributable to costs incurred after 2006, the otherwise applicable Federal matching rate shall be increased to 100 percent.

''(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935 of such Act, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2003) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including

such a plan operating under a waiver under section 1115).

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2003 is 80 percent;

''(B) 2004 is 60 percent;

''(C) 2005 is 40 percent;

''(D) 2006 is 20 percent; or

''(E) a year after 2006 is 0 percent.''.

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935 of such Act, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual dually entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935 of such Act, as so inserted and amended, is further amended—

(A) in subsection (a)(1), by inserting ''subject to subsection (e),'' after ''section 1903 '';

(B) in subsection (c)(1), by inserting ''subject to subsection (e),'' after ''1903(a)''; and

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

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2003, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860(b)(5) for the year involved.

''(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(f) of such Act is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

SEC. 104. MEDIGAP TRANSITION PROVISIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under section 1882 of the Social Security Act on or after January 1, 2003, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—

(1) IN GENERAL.—The issuer of a medicare supplemental policy—

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', ''D'', ''E'', ''F'', or ''G'' (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act, 42 U.S.C. 1395ss) and that is offered and is available for issuance to new enrollees by such issuer;

(B) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(C) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(2) INDIVIDUAL COVERED.—An individual described in this paragraph is an individual who—

(A) enrolls in a prescription drug plan under part D of title XVIII of the Social Security Act; and

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ''H'', ''I'', or ''J'' under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(3) ENFORCEMENT.—The provisions of paragraph (1) shall be enforced as though they were included in section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)).

(4) DEFINITIONS.—For purposes of this subsection, the term ''medicare supplemental policy'' has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

Subtitle A—Medicare Benefits Administration

SEC. 201. ESTABLISHMENT OF ADMINISTRATION.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1806 the following new section:

''MEDICARE BENEFITS ADMINISTRATION

''SEC. 1807. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5

years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Health Care Financing Administration in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

''(C) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration.

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

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

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

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE HEALTH CARE FINANCING ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Health Care Financing Administration shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Health Care Financing Administration to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Health Care Financing Administration transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Health Care Financing Administration as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Health Care Financing Administration is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Health Care Financing Administration in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, a PDP sponsor under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) 3 members shall be appointed by the President.

''(ii) 2 members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Commerce of the House of Representatives.

''(iii) 2 members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) 1 shall be appointed for a term of 1 year;

''(ii) 3 shall be appointed for terms of 2 years; and

''(iii) 3 shall be appointed for terms of 3 years.

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

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

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) STAFF.—With the approval of the Board, the Director may appoint and fix the pay of such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY IN APPLICATION OF CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The Director and staff of the Board shall be appointed without regard to the provisions of chapter 31 of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and General Schedule pay rates).

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

''(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) EFFECTIVE DATE.—

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

(2) TIMING OF INITIAL APPOINTMENTS.—The Administrator and Deputy Administrator of the Medicare Benefits Administration may not be appointed before March 1, 2001.

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning or after January 1, 2003.

SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) of the Social Security Act (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting '', the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

''Administrator of the Health Care Financing Administration.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2001.

Subtitle B—Oversight of Financial Sustainability of the Medicare Program

SEC. 211. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 of the Social Security Act (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—

''(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (in this subsection referred to as the 'Trust Funds'). Such report shall included the following information:

''(A) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title, stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

''(B) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

''(C) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (A) required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

''(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

''(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published by the Committee on Ways and Means as a public document and shall be made available by such Committee on the Internet.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of the enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act.

Subtitle C—Changes in Medicare Coverage and Appeals Process

SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended to read as follows:

''DETERMINATIONS; APPEALS

''SEC. 1869. (a) INITIAL DETERMINATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in

accordance with those regulations for the following:

''(1) The initial determination of whether an individual is entitled to benefits under such parts.

''(2) The initial determination of the amount of benefits available to the individual under such parts.

''(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

''(b) APPEAL RIGHTS.—

''(1) IN GENERAL.—

''(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

''(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

''(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

''(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

''(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

''(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

''(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

''(D) TIME LIMITS FOR APPEALS.—

''(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described subparagraph (A) files notice with the Secretary to request reconsideration by not later than 180 days after the individual receives notice of the initial determination under subsection (a) or within such additional time as the Secretary may allow.

''(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

''(E) AMOUNTS IN CONTROVERSY.—

''(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

''(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow 2 or more appeals to be aggregated if the appeals involve—

''(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

''(II) common issues of law and fact arising from services furnished to 2 or more individuals by one or more providers of services or suppliers.

''(F) EXPEDITED PROCEEDINGS.—

''(i) EXPEDITED DETERMINATION.—In the case of an individual who—

''(I) has received notice by a provider of services that the provider of services plans to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

''(II) has received notice by a provider of services that the provider of services plans to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

''(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

''(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

''(2) REVIEW OF COVERAGE DETERMINATIONS.—

''(A) NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

''(I) Such a determination shall not be reviewed by any administrative law judge.

''(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

''(III) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(IV) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(ii) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Secretary respecting whether or not a particular item or service is covered under this title, including such a determination under 1862(a)(1).

''(B) LOCAL COVERAGE DETERMINATION.—In the case of a local coverage determination made by a fiscal intermediary or a carrier under part A or part B respecting whether a particular type or class of items or services is covered under such parts, the following limitations apply:

''(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(ii) Such a determination may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(C) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of review of a determination under subparagraph (A)(i)(III) or (B)(i) where the moving party alleges that there are no material issues of fact in dispute, and alleges that the only issue is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction.

''(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

''(I) Issue a national coverage determination, with or without limitations.

''(II) Issue a national noncoverage determination.

''(III) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

''(IV) Issue a notice that states that the Secretary has not completed a review of the national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

''(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

''(iii) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination.

An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

''(3) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

''(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

''(5) STANDING.—An action under this section seeking review of a coverage determination (with respect to items and services under this title) may be initiated only by one (or more) of the following aggrieved persons, or classes of persons:

''(A) Individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services involved in the coverage determination.

''(B) Persons, or classes of persons, who make, manufacture, offer, supply, make available, or provide such items and services.

''(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under paragraphs (2) and (3) of subsection (a). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

''(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term 'qualified independent contractor' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a), and that meets the requirements established by the Secretary consistent with paragraph (3).

''(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the following requirements:

''(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required under regulations of the Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

''(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

''(i) such payment is allowed by reason of section 1879;

''(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

''(iii) such determination is changed as the result of any hearing by the Secretary or judicial review of the decision under this section; or

''(iv) such payment is authorized under section 1861(v)(1)(G).

''(C) DEADLINES FOR DECISIONS.—

''(i) DETERMINATIONS.—The qualified independent contractor shall conduct and conclude a determination under subparagraph (B) or an appeal of an initial determination, and mail the notice of the decision by not later than the end of the 45-day period beginning on the date a request for reconsideration has been timely filed.

''(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i), the party requesting the reconsideration or appeal may request a hearing before an administrative law judge, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

''(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or of a decision of the provider of services to discharge the individual from the provider of services, in accordance with the following:

''(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j), not later than 1 day after the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

''(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

''(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

''(i) PHYSICIANS.—No physician under the employ of a qualified independent contractor may review—

''(I) determinations regarding health care services furnished to a patient if the physician was directly responsible for furnishing such services; or

''(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the physician's family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

''(ii) PHYSICIAN'S FAMILY DESCRIBED.—For purposes of this paragraph, a physician's family includes the physician's spouse (other than a spouse who is legally separated from the physician under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents.

''(E) EXPLANATION OF DETERMINATIONS.—Any determination of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the determination as well as a discussion of the pertinent facts and applicable regulations applied in making such determination.

''(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

''(G) DISSEMINATION OF INFORMATION.—Each qualified independent contractor shall, using the methodology established by the Secretary under subsection (d)(4), make available all determinations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, and other entities under contract with the Secretary to make initial determinations under part A or part B or title XI.

''(H) ENSURING CONSISTENCY IN DETERMINATIONS.—Each qualified independent contractor shall monitor its determinations to ensure consistency of determinations with respect to requests for reconsideration of similar or related matters.

''(I) DATA COLLECTION.—

''(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

''(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

''(I) Specific claims that give rise to appeals.

''(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

''(III) Situations suggesting the need for changes in national or local coverage policy.

''(IV) Situations suggesting the need for changes in local medical review policies.

''(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

''(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the Secretary for a hearing, including as necessary, explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

''(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not more than 12 qualified independent contractors under this subsection.

''(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified

independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

''(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

''(A) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall promulgate regulations governing the processes of reconsiderations of determinations by the Secretary and qualified independent contractors and of hearings by the Secretary. Such regulations shall include such specific criteria and provide such guidance as required to ensure the adequate functioning of the reconsiderations and hearings processes and to ensure consistency in such processes.

''(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

''(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

''(II) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

''(II) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subclause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

''(ii) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (B) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

''(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

''(iv) DAB HEARING PROCEDURE.—In the case of a request described in clause (iii), the Departmental Appeals Board shall review the case de novo.

''(C) POLICIES.—The Secretary shall provide such specific criteria and guidance, including all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

''(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

''(E) EFFECT OF FAILURE TO PUBLISH POLICIES.—

''(i) NATIONAL AND LOCAL COVERAGE POLICIES.—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

''(ii) OTHER POLICIES.—With respect to policies established by the Secretary other than the policies described in clause (i), qualified independent contractors shall not be bound by such policies if the Secretary does not furnish to the qualified independent contractor the policies in a published format consistent with subparagraph (C).

''(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—

''(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

''(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight may not be delegated to regional offices of the Department.

''(4) DISSEMINATION OF DETERMINATIONS.—The Secretary shall establish a methodology under which qualified independent contractors shall carry out subsection (c)(3)(G).

''(5) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

''(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.''.

(b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO MEDICARE+CHOICE INDEPENDENT APPEALS CONTRACTORS.—Section 1852(g)(4) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at the end the following: ''The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.''.

(c) CONFORMING AMENDMENT TO REVIEW BY THE PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g)) is amended by adding at the end the following new paragraph:

''(3) Findings described in paragraph (1) and determinations and other decisions described in paragraph (2) may be reviewed or appealed under section 1869.''.

SEC. 222. PROVISIONS WITH RESPECT TO LIMITATIONS ON LIABILITY OF BENEFICIARIES.

(a) EXPANSION OF LIMITATION OF LIABILITY PROTECTION FOR BENEFICIARIES WITH RESPECT TO MEDICARE CLAIMS NOT PAID OR PAID INCORRECTLY.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsections:

''(i) Notwithstanding any other provision of this Act, an individual who is entitled to benefits under this title and is furnished a service or item is not liable for repayment to the Secretary of amounts with respect to such benefits—

''(1) subject to paragraph (2), in the case of a claim for such item or service that is incorrectly paid by the Secretary; and

''(2) in the case of payments made to the individual by the Secretary with respect to any claim under paragraph (1), the individual shall be liable for repayment of such amount only up to the amount of payment received by the individual from the Secretary.

''(j)(1) An individual who is entitled to benefits under this title and is furnished a service or item is not liable for payment of amounts with respect to such benefits in the following cases:

''(A) In the case of a benefit for which an initial determination has not been made by the Secretary under subsection (a) whether payment may be made under this title for such benefit.

''(B) In the case of a claim for such item or service that is—

''(i) improperly submitted by the provider of services or supplier; or

''(ii) rejected by an entity under contract with the Secretary to review or pay claims for services and items furnished under this title, including an entity under contract with the Secretary under section 1857.

''(2) The limitation on liability under paragraph (1) shall not apply if the individual signs a waiver provided by the Secretary under subsection (l) of protections under this paragraph, except that any such waiver shall not apply in the case of a denial of a claim for noncompliance with applicable regulations or procedures under this title or title XI.

''(k) An individual who is entitled to benefits under this title and is furnished services by a provider of services is not liable for payment of amounts with respect to such services prior to noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), unless the following conditions are met:

''(1) The provider of services shall furnish a notice of discharge and appeal rights established by the Secretary under subsection (l) to each individual entitled to benefits under this title to whom such provider of services furnishes services, upon admission of the individual to the provider of services and upon notice of determination to discharge the individual from the provider of services, of the individual's limitations of liability under this section and rights of appeal under section 1869.

''(2) If the individual, prior to discharge from the provider of services, appeals the determination to discharge under section 1869 not later than noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), the provider of services shall, by the close of business of such first working day, provide to the Secretary (or qualified independent contractor under section 1869, as determined by the Secretary) the records required to review the determination.

''(l) The Secretary shall develop appropriate standard forms for individuals entitled to benefits under this title to waive limitation of liability protections under subsection (j) and to receive notice of discharge and appeal rights under subsection (k). The forms developed by the Secretary under this subsection shall clearly and in plain language inform such individuals of their limitations on liability, their rights under section 1869(a) to obtain an initial determination by the Secretary of whether payment may be made under part A or part B for such benefit, and their rights of appeal under section 1869(b), and shall inform such individuals that they may obtain further information or file an appeal of the determination by use of the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) maintained by the Secretary. The forms developed by the Secretary under this subsection shall be the only manner in which such individuals may waive such protections under this title or title XI.

''(m) An individual who is entitled to benefits under this title and is furnished an item or service is not liable for payment of cost sharing amounts of more than $50 with respect to such benefits unless the individual has been informed in advance of being furnished the item or service of the estimated amount of the cost sharing for the item or service using a standard form established by the Secretary.''.

(2) CONFORMING AMENDMENT.—Section 1870(a) of the Social Security Act (42 U.S.C. 1395gg(a)) is amended by striking ''Any payment under this title'' and inserting ''Except as provided in section 1879(i), any payment under this title''.

(b) INCLUSION OF BENEFICIARY LIABILITY INFORMATION IN EXPLANATION OF MEDICARE BENEFITS.—Section 1806(a) of the Social Security Act (42 U.S.C. 1395b–7(a)) is amended—

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

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) lists with respect to each item or service furnished the amount of the individual's liability for payment;'';

(4) in paragraph (3), as so redesignated, by striking the period at the end and inserting ''; and''; and

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

''(4) includes the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) for information and questions concerning the statement, liability of the individual for payment, and appeal rights.''.

SEC. 223. WAIVERS OF LIABILITY FOR COST SHARING AMOUNTS.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amended by striking clauses (i) through (iii) and inserting the following:

''(i) the waiver is offered as a part of a supplemental insurance policy or retiree health plan;

''(ii) the waiver is not offered as part of any advertisement or solicitation, other than in conjunction with a policy or plan described in clause (i);

''(iii) the person waives the coinsurance and deductible amount after the beneficiary informs the person that payment of the coinsurance or deductible amount would pose a financial hardship for the individual; or

''(iv) the person determines that the coinsurance and deductible amount would not justify the costs of collection.''.

(b) CONFORMING AMENDMENT.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) In this section, the term 'remuneration' includes the meaning given such term in section 1128A(i)(6).''.

SEC. 224. ELIMINATION OF MOTIONS BY THE SECRETARY ON DECISIONS OF THE PROVIDER REIMBURSEMENT REVIEW BOARD.

Section 1878(f)(1) of such Act (42 U.S.C. 1395oo(f)(1)) is amended—

(1) in the first sentence, by striking ''unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision'';

(2) in the second sentence, by striking '', or of any reversal, affirmance, or modification by the Secretary,'' and ''or of any reversal, affirmance, or modification by the Secretary''; and

(3) in the fifth sentence, by striking '' and not subject to review by the Secretary''.

TITLE III—MEDICARE+CHOICE REFORMS; PRESERVATION OF MEDICARE PART B DRUG BENEFIT

Subtitle A—Medicare+Choice Reforms

SEC. 301. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0.4 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0.2 percentage points''.

SEC. 302. PERMANENTLY REMOVING APPLICATION OF BUDGET NEUTRALITY BEGINNING IN 2002.

Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), in the matter following clause (ii), by inserting ''(for years before 2002)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(before 2002)'' after ''for each year''.

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853(c)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is amended—

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

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

''(II) For 2002 for any of the 50 States and the District of Columbia, $450.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to years beginning with 2002.

SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

(a) IN GENERAL.—Section 1853(c)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) in clause (i), by striking ''(ii) For a subsequent year'' and inserting ''(ii)(I) Subject to subclause (II), for a subsequent year''; and

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

''(II) During 2002, 2003, 2004, and 2005, in the case of a Medicare+Choice payment area in which there is no more than 1 contract entered into under this part as of July 1 before the beginning of the year, 102.5 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(b) CONSTRUCTION.—The amendments made by subsection (a) do not affect the payment of a first time bonus under section 1853(i) of the Social Security Act (42 U.S.C. 1395w–23(i)).

SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN CERTAIN MEDICARE+CHOICE PAYMENT AREAS BELOW NATIONAL AVERAGE.

Section 1853(c)(1) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(1) in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''; and

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

''(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

''(i) IN GENERAL.—For each year beginning with 2004, in the case of a Medicare+Choice payment area for which the Medicare+Choice capitation rate under this paragraph would otherwise be less than the United States per capita cost (USPCC), as calculated by the Secretary, a Medicare+Choice organization may negotiate with the Medicare Benefits Administrator an annual per capita rate that—

''(I) reflects an annual rate of increase up to the rate of increase specified in clause (ii);

''(II) takes into account audited current data supplied by the organization on its adjusted community rate (as defined in section 1854(f)(3)); and

''(III) does not exceed the United States per capita cost, as projected by the Secretary for the year involved.

''(ii) MAXIMUM RATE DESCRIBED.—The rate of increase specified in this clause for a year is the rate of inflation in private health insurance for the year involved, as projected by the Medicare Benefits Administrator, and includes such adjustments as may be necessary—

''(I) to reflect the demographic characteristics in the population under this title; and

''(II) to eliminate the costs of prescription drugs.

''(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.''.

SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED ON DATA FROM ALL SETTINGS.

Section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

''and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the methodology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.''.

Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

The SPEAKER pro tempore. The amendment recommended by the Committee on Ways and Means now printed in the bill, modified by the amendment printed in House Report 106–703, is adopted.

The text of H.R. 4680, as amended, as modified, is as follows:

H.R. 4680

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 ''Medicare Rx 2000 Act''.

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

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

''(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

''(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in the plan and obtain coverage through such plan.

''(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860C(a)).

Such individuals shall have a choice of such plans under section 1860E(d).

''(b) GENERAL ELECTION PROCEDURES.—

''(1) IN GENERAL.—An individual may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1807(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

''(2) ELECTION PERIODS.—

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

''(i) annual coordinated election periods; and

''(ii) special election periods.

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

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is enrolled under part B as of November 1, 2002, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first enrolled under part B after November 1, 2002, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

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

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

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

''(iii) in the case of an individual who meets such exceptional conditions (including conditions recognized under section 1851(d)(4)(D)) as the Administrator may provide.

''(D) ONE-TIME ENROLLMENT PERMITTED FOR CURRENT PART A ONLY BENEFICIARIES.—In the case of an individual who as of November 1, 2002—

''(i) is entitled to benefits under part A; and

''(ii) is not (and has not previously been) enrolled under part B;

the individual shall be eligible to enroll in a prescription drug plan under this part but only during the period described in subparagraph (B)(i). If the individual enrolls in such a plan, the individual may change such enrollment

under this part, but the individual may not enroll in a Medicare+Choice plan under part C unless the individual enrolls under part B. Nothing in this subparagraph shall be construed as providing for coverage under a prescription drug plan of benefits that are excluded because of the application of section 1860B(f)(2)(B).

''(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

''(2) COMMUNITY-RATED PREMIUM.—

''(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since first qualifying to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

''(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage, a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) increase the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

''(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after a date if the individual establishes that there is no period of 63 days or longer on and after such date (beginning not earlier than January 1, 2003) during all of which the individual did not have any of the following prescription drug coverage:

''(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

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

''(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1).

''(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2003, and only until the date such coverage is terminated.

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

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

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

''(E) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

''(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(d) EFFECTIVE DATE OF ELECTIONS.—

''(1) IN GENERAL.—Except as provided in this section, the Medicare Benefits Administrator shall provide that elections under subsection (b) take effect at the same time as the Secretary provides that similar elections under section 1851(e) take effect under section 1851(f).

''(2) NO ELECTION EFFECTIVE BEFORE 2003.—In no case shall any election take effect before January 1, 2003.

''(3) TERMINATION.—The Medicare Benefits Administrator shall provide for the termination of an election in the case of—

''(A) termination of coverage under part B (other than the case of an individual described in subsection (b)(2)(D) (relating to part A only individuals)); and

''(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

''SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENTS.—

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

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

''(B) DISAPPROVAL AUTHORITY.—The Medicare Benefits Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is purposefully engaged in activities intended to result in favorable selection of those eligible medicare beneficiaries obtaining coverage through the plan, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

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

''(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

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

''(A) for 2003, that is equal to $250; or

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

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

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

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

''(A) for 2003, that is equal to $2,100; or

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

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

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

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits without any cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(i) for 2003, is equal to $6,000; or

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

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

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

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

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

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

''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the following requirements are met:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the reinsurance subsidy payments under section 1860H with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (b)(1) and the initial coverage limit under subsection (b)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (b)(2).

''(2) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES.—The coverage provides the limitation on out-of-pocket expenditures by beneficiaries described in subsection (b)(4).

''(d) ACCESS TO NEGOTIATED PRICES.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs.

''(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

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

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

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

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

''(B) for determining annual percentage increases described in subsection (b)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

''(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

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

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

''(2) EXCLUSIONS.—

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

''(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B (but shall be so considered if such payment is not available because benefits under part A or B have been exhausted), without regard to whether the individual is entitled to benefits under part A or enrolled under part B.

''(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary that meets the requirements of section 1860C(f)(2) (including providing an appeal process).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

''(5) STUDY ON INCLUSION OF DRUGS TREATING MORBID OBESITY.—The Medicare Policy Advisory Board shall provide for a study on removing the exclusion under paragraph (2)(A) for coverage of agents used for weight loss in the case of morbidly obese individuals. The Board shall report to Congress on the results of the study not later than March 1, 2002.

''SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) GUARANTEED ISSUE COMMUNITY-RELATED PREMIUMS AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), and 1860F(b).

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

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

''(B) How any formulary used by the sponsor functions.

''(C) Co-payments and deductible requirements.

''(D) Grievance and appeals procedures.

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

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ASSURING PHARMACY ACCESS.—The PDP sponsor of the prescription drug plan shall secure the participation of sufficient numbers of pharmacies (which may include mail order pharmacies) to ensure convenient access (including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access. Nothing in this paragraph shall be construed as requiring the participation of (or permitting the exclusion of) all pharmacies in any area under a plan.

''(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—The PDP sponsor of a prescription drug plan shall issue such a card that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—Insofar as a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

''(A) FORMULARY COMMITTEE.—The sponsor must establish a pharmaceutical and therapeutic committee that develops the formulary. Such committee shall include at least one physician and at least one pharmacist.

''(B) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within all therapeutic categories and classes of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The PDP sponsor must have, as part of the appeals process under subsection (f)(2), a process for appeals for denials of coverage based on such application of the formulary.

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

''(1) IN GENERAL.—The PDP sponsor shall have in place—

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

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2); and

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

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce

the risk of adverse events, including adverse drug interactions.

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

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

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

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

''(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

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

''(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

''(B) Subsection (c)(1) (relating to access to covered benefits).

''(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR GENERIC EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug that is therapeutically and pharmaceutically equivalent and bioequivalent.

''(e) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

''(f) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—A PDP sponsor shall meet the requirements of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) APPEALS OF FORMULARY DETERMINATIONS.—Under the appeals process under paragraph (1) an individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a covered outpatient drug that is not on the formulary of the sponsor (established under subsection (c)) if the prescribing physician determines that the therapeutically similar drug that is on the formulary is not as effective for the enrollee or has significant adverse effects for the enrollee.

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

''SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

''(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

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

''(2) ASSUMPTION OF FULL FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under reinsurance under section 1860H.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Medicare Benefits Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than 1 prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Medicare Benefits Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the reinsurance subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

''(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

''(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

''(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

''(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

''(i) such section shall be applied separately to costs relating to this part (from costs under part C);

''(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

''(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

''(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

''(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

''(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

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

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

''(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

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

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

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

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

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

''(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

''(1) ESTABLISHMENT.—The Medicare Benefits Administrator shall establish, by not later than October 1, 2001, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

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

''(e) OTHER STANDARDS.—The Medicare Benefits Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2001. In order to carry out this requirement in a timely manner, the Administrator may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(f) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this section shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to prescription drug

plans which are offered by PDP sponsors under this part to the extent such law or regulation is inconsistent with such standards.

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

''(A) Benefit requirements.

''(B) Requirements relating to inclusion or treatment of providers.

''(C) Coverage determinations (including related appeals and grievance processes).

''(D) Establishment and regulation of premiums.

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Medicare Benefits Administrator under this part.

''SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) IN GENERAL.—The Medicare Benefits Administrator, through the Office of Beneficiary Assistance, shall establish, based upon and consistent with the procedures used under part C (including section 1851), a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

''(b) ELEMENTS.—Such process shall include the following:

''(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

''(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-federal entities.

''(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

''(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

''(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(1) CHOICE OF AT LEAST 2 PLANS IN EACH AREA.—

''(A) IN GENERAL.—The Medicare Benefits Administrator shall assure that each individual who is enrolled under part B and who is residing in an area has available, consistent with subparagraph (B), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

''(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Medicare Benefits Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Medicare Benefits Administrator—

''(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

''(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

''(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

''(4) REPORTS.—The Medicare Benefits Administrator shall, in each annual report to Congress under section 1807(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

''(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

''SEC. 1860F. PREMIUMS.

''(a) SUBMISSION OF PREMIUMS AND RELATED INFORMATION.—

''(1) IN GENERAL.—Each PDP sponsor shall submit to the Medicare Benefits Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

''(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

''(A) Information on the qualified prescription drug coverage to be provided.

''(B) Information on the actuarial value of the coverage.

''(C) Information on the monthly premium to be charged for the coverage, including an actuarial certification of—

''(i) the actuarial basis for such premium;

''(ii) the portion of such premium attributable to benefits in excess of standard coverage; and

''(iii) the reduction in such premium resulting from the reinsurance subsidy payments provided under section 1860H.

''(D) Such other information as the Medicare Benefits Administrator may require to carry out this part.

''(3) REVIEW.—The Medicare Benefits Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

''(b) UNIFORM PREMIUM.—The premium for a prescription drug plan charged under this section may not vary among individuals enrolled in the plan in the same service area, except as is permitted under section 1860A(c)(2)(B) (relating to late enrollment penalties).

''(c) TERMS AND CONDITIONS FOR IMPOSING PREMIUMS.—The provisions of section 1854(d) shall apply under this part in the same manner as they apply under part C, and, for this purpose, the reference in such section to section 1851(g)(3)(B)(i) is deemed a reference to section 1860A(d)(3)(B) (relating to failure to pay premiums required under this part).

''(d) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

''(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the reference premium under section 1860G(b)(2) as payment in full for the premium charge for qualified prescription drug coverage.

''(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

''SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

''(a) IN GENERAL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

''(A) to a premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that are nominal.

''(2) SLIDING SCALE PREMIUM SUBSIDY FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to a premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

''(3) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

''(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

''(ii) has income below 150 percent of the Federal poverty line; and

''(iii) meets the resources requirement described in section 1905(p)(1)(C).

''(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Medicare Benefits Administrator.

''(C) INCOME DETERMINATIONS.—For purposes of applying this section—

''(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

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

''(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

''(b) PREMIUM SUBSIDY AMOUNT.—

''(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the reference premium (as defined in paragraph (2)) for qualified

prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

''(2) REFERENCE PREMIUM DEFINED.—For purposes of this subsection, the term 'reference premium' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the premium imposed for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a Medicare+Choice plan, the standard premium computed under section 1851(j)(5)(A)(iii), determined without regard to any reduction effected under section 1851(j)(5)(B).

''(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

''(1) IN GENERAL.—In applying subsection (a)(1)(B)—

''(A) the maximum amount of subsidy that may be provided with respect to an enrollee for a year may not exceed 95 percent of the maximum cost-sharing described in such subsection that may be incurred for standard coverage;

''(B) the Medicare Benefits Administrator shall determine what is 'nominal' taking into account the rules applied under section 1916(a)(3); and

''(C) nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor may not charge more than a nominal amount in cases in which the cost-sharing subsidy is provided under such subsection.

''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Medicare Benefits Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

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

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

''(e) RELATION TO MEDICAID PROGRAM.—

''(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES THROUGH REINSURANCE FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REINSURANCE SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Medicare Benefits Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

''(1) for individuals enrolled with a prescription drug plan under this part;

''(2) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

''(3) for medicare primary individuals (described in subsection (f)(3)(D)) who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) A PDP sponsor offering a prescription drug plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(2) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds $1,250, but does not exceed $1,350, an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

''(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,350, but does not exceed $1,450, an amount equal to 50 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(C) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,450, but does not exceed $1,550, an amount equal to 70 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(D) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,550, but does not exceed $2,350, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(E) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $7,050, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INDEXING DOLLAR AMOUNTS.—

''(A) AMOUNTS FOR 2003.—The dollar amounts applied under paragraph (1) for 2003 shall be the dollar amounts specified in such paragraph.

''(B) FOR 2004.—The dollar amounts applied under paragraph (1) for 2004 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2004.

''(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2004 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) for the year involved.

''(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(d) ADJUSTMENT OF PAYMENTS.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall estimate—

''(A) the total payments to be made (without regard to this subsection) during a year under this section; and

''(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(2) ADJUSTMENT OF PAYMENTS.—The Administrator shall proportionally adjust the payments made under this section for a coverage year in such manner so that the total of the payments made for the year under this section is equal to 35 percent of the total payments described in paragraph (1)(B) during the year.

''(e) PAYMENT METHODS.—

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

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

''(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Medicare Benefits Administrator may require, that the coverage meets the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Medicare Benefits Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to

ensure the adequacy of prescription drug coverage, the accuracy of payments made, and such other matters as may be appropriate.

''(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

''(D) OTHER REQUIREMENTS.—The sponsor of the plan shall comply with such other requirements as the Medicare Benefits Administrator finds necessary to administer the program under this section.

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is a medicare primary individual who—

''(A) is covered under the plan; and

''(B) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

''(3) DEFINITIONS.—As used in this section:

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for medicare primary individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

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

''(D) MEDICARE PRIMARY INDIVIDUAL.—The term 'medicare primary individual' means, with respect to a plan, an individual who is covered under the plan and with respect to whom the plan is not a primary plan (as defined in section 1862(b)(2)(A)).

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled with a prescription drug plan under this part;

''(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

''(C) is covered as a medicare primary individual under a qualified retiree prescription drug plan.

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

''SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.

''(a) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Medicare Prescription Drug Account' (in this section referred to as the 'Account'). The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Medicare Benefits Administrator certifies are necessary to make—

''(A) payments under section 1860G (relating to low-income subsidy payments);

''(B) payments under section 1860H (relating to reinsurance subsidy payments); and

''(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(3) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) DEPOSITS INTO ACCOUNT.—

''(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b), reduced by the amount transferred to the Account under paragraph (1).

''SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

''(a) DEFINITIONS.—For purposes of this part:

''(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

''(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(3) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term 'Medicare Prescription Drug Account' means the Account in the Federal Supplementary Medical Insurance Trust Fund created under section 1860I(a).

''(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

''(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

''(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Medicare Benefits Administrator and the sponsor under section 1860D(b);

''(B) provides qualified prescription drug coverage; and

''(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

''(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

''(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

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

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

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts'', and

(B) by inserting before the period the following: ''and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860I''; and

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Medicare Prescription Drug Account in the Trust Fund),''.

(c) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

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

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

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

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D. The Medicare Benefits Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) TREATMENT OF COVERAGE.—Except as provided in this subsection, qualified prescription drug coverage offered under this subsection shall be treated under this part in the same manner as supplemental health care benefits described in section 1852(a)(3)(A).

''(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

''(B) providing a Medicare+Choice organization with reinsurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

''(5) SPECIFICATION OF SEPARATE AND STANDARD PREMIUM.—

''(A) IN GENERAL.—For purposes of applying section 1854 and section 1860G(b)(2)(B) with respect to qualified prescription drug coverage offered under this subsection under a plan, the

Medicare+Choice organization shall compute and publish the following:

''(i) SEPARATE PRESCRIPTION DRUG PREMIUM.—A premium for prescription drug benefits that constitute qualified prescription drug coverage that is separate from other coverage under the plan.

''(ii) PORTION OF COVERAGE ATTRIBUTABLE TO STANDARD BENEFITS.—The ratio of the actuarial value of standard coverage to the actuarial value of the qualified prescription drug coverage offered under the plan.

''(iii) PORTION OF PREMIUM ATTRIBUTABLE TO STANDARD BENEFITS.—A standard premium equal to the product of the premium described in clause (i) and the ratio under clause (ii).

The premium under clause (i) shall be compute without regard to any reduction in the premium permitted under subparagraph (B).

''(B) REDUCTION OF PREMIUMS ALLOWED.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from reducing the amount of a premium charged for prescription drug coverage because of the application of section 1854(f)(1)(A) to other coverage.

''(C) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—For requirement to accept reference premium as full premium if there is no standard (or equivalent) coverage in the area of a Medicare+Choice plan, see section 1860F(d).

''(6) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2003 shall be the 6-month period beginning with November 2002.

''(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860B.''.

(b) CONFORMING AMENDMENTS.—Section 1851 of such Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

''and may elect qualified prescription drug coverage in accordance with section 1860A.''; and

(2) in subsection (g)(1), by inserting ''and section 1860A(c)(2)(B)'' after ''in this subsection''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2003.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (64);

(ii) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(iii) by inserting after paragraph (65) the following new paragraph:

''(66) provide for making eligibility determinations under section 1935(a).''.

(2) NEW SECTION.—Title XIX of such Act is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

''(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows:

''(A) For expenditures attributable to costs incurred during 2003, the otherwise applicable Federal matching rate shall be increased by 20 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B) For expenditures attributable to costs incurred during 2004, the otherwise applicable Federal matching rate shall be increased by 40 percent of the percentage otherwise payable (but for this subsection) by the State.

''(C) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

''(D) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 80 percent of the percentage otherwise payable (but for this subsection) by the State.

''(E) For expenditures attributable to costs incurred after 2006, the otherwise applicable Federal matching rate shall be increased to 100 percent.

''(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935 of such Act, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2003) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2003 is 80 percent;

''(B) 2004 is 60 percent;

''(C) 2005 is 40 percent;

''(D) 2006 is 20 percent; or

''(E) a year after 2006 is 0 percent.''.

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935 of such Act, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual dually entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935 of such Act, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting ''subject to subsection (e)'' after ''section 1903(a)'';

(B) in subsection (c)(1), by inserting ''subject to subsection (e)'' after ''1903(a)(1)''; and

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

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2003, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860B(b)(5) for the year involved.

''(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(f) of such Act is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

SEC. 104. MEDIGAP TRANSITION PROVISIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under section 1882 of the Social Security Act on or after January 1, 2003, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—

(1) IN GENERAL.—The issuer of a medicare supplemental policy—

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', ''D'', ''E'', ''F'', or ''G'' (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act, 42 U.S.C. 1395ss) and that is offered and is available for issuance to new enrollees by such issuer;

(B) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(C) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(2) INDIVIDUAL COVERED.—An individual described in this paragraph is an individual who—

(A) enrolls in a prescription drug plan under part D of title XVIII of the Social Security Act; and

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ''H'', ''I'', or ''J'' under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(3) ENFORCEMENT.—The provisions of paragraph (1) shall be enforced as though they were included in section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)).

(4) DEFINITIONS.—For purposes of this subsection, the term ''medicare supplemental policy'' has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

SEC. 105. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established as of October 1, 2000, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the ''Commission'') to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the medicare prescription drug program under part D of title XVIII of the Social Security Act.

(2) DEFINITIONS.—For purposes of this section:

(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term ''State pharmaceutical assistance program'' means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act assistance to low-income medicare beneficiaries for the purchase of prescription drugs.

(B) PROGRAM PARTICIPANT.—The term ''program participant'' means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) COMPOSITION.—The Commission shall consist of the following:

(1) A representative of each governor of each State that the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under part D of title XVIII of the Social Security Act.

(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(3) Representatives of organizations that represent the interests of program participants, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

(4) The Secretary (or the Secretary's designee). The Secretary shall designate a member to serve as chair of the Commission and the Commission shall meet at the call of the chair.

(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants.

(2) Protection of the financial interests of States so that States are not financially worse off as a result of the enactment of this title.

(d) REPORT.—By not later than July 1, 2001, the Commission shall submit to the President and the Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

SEC. 106. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Administrator of the Medicare Benefits Administration (in this section referred to as the ''Administrator'') shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the impact on costs and health outcomes of applying disease management to medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. In no case may the number of participants in the project exceed 30,000 at any time.''.

(b) VOLUNTARY PARTICIPATION.—

(1) ELIGIBILITY.—Medicare beneficiaries are eligible to participate in the project only if—

(A) they meet specific medical criteria demonstrating the appropriate diagnosis and the advanced nature of their disease;

(B) their physicians approve of participation in the project; and

(C) they are not enrolled in a Medicare+Choice plan.

(2) BENEFITS.—A beneficiary who is enrolled in the project shall be eligible—

(A) for disease management services related to their chronic health condition; and

(B) if the beneficiary—

(i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act, for payment of any premiums for such plan, any deductible or cost-sharing, and any amounts not covered under the plan because of the application of an initial coverage limit; or

(ii) is not enrolled in such a plan, for payment for all costs for prescription drugs without regard to whether or not they relate to the chronic health condition;

except that the project may provide for modest cost-sharing with respect to prescription drug coverage.

(3) TREATMENT AS QUALIFYING COVERAGE FOR PURPOSES OF CONTINUOUS COVERAGE.—For purposes of applying section 1860A(c)(2)(C) of the Social Security Act, coverage under the project shall be treated as coverage under a prescription drug plan under part D of title XVIII of such Act.

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Administrator shall carry out the project through contracts with up to 3 disease management organizations. The Administrator shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Administrator in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program) there will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the net reduction in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

(d) DURATION.—The project shall last for not longer than 3 years.

(e) REPORT.—The Administrator shall submit to Congress an interim report on the project not later than 2 years after the date it is first implemented and a final report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on costs and health outcomes and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

Subtitle A—Medicare Benefits Administration

SEC. 201. ESTABLISHMENT OF ADMINISTRATION.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1806 the following new section:

''MEDICARE BENEFITS ADMINISTRATION

''SEC. 1807. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Health Care Financing Administration in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

''(C) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

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

''(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

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

''(D) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration.

''(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

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

''(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT HCFA FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Health Care Financing Administration and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Health Care Financing Administration to conduct such functions as of the date of the enactment of this Act.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE HEALTH CARE FINANCING ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Health Care Financing Administration shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Health Care Financing Administration to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Health Care Financing Administration transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Health Care Financing Administration as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Health Care Financing Administration is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Health Care Financing Administration in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, a PDP sponsor under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Policy Advisory

Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) 3 members shall be appointed by the President.

''(ii) 2 members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Commerce of the House of Representatives.

''(iii) 2 members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) 1 shall be appointed for a term of 1 year;

''(ii) 3 shall be appointed for terms of 2 years; and

''(iii) 3 shall be appointed for terms of 3 years.

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

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

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

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

''(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) EFFECTIVE DATE.—

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

(2) TIMING OF INITIAL APPOINTMENTS.—The Administrator and Deputy Administrator of the Medicare Benefits Administration may not be appointed before March 1, 2001.

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning or after January 1, 2003.

SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) of the Social Security Act (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting ''the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

''Administrator of the Health Care Financing Administration.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2001.

Subtitle B—Oversight of Financial Sustainability of the Medicare Program

SEC. 211. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 of the Social Security Act (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—

''(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (in this subsection referred to as the 'Trust Funds'). Such report shall included the following information:

''(A) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title, stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

''(B) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

''(C) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (A) required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

''(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

''(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published by the Committee on Ways and Means as a public document and shall be made available by such Committee on the Internet.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of the enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act.

Subtitle C—Changes in Medicare Coverage and Appeals Process

SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended to read as follows:

''DETERMINATIONS; APPEALS

''SEC. 1869. (a) INITIAL DETERMINATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

''(1) The initial determination of whether an individual is entitled to benefits under such parts.

''(2) The initial determination of the amount of benefits available to the individual under such parts.

''(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

''(b) APPEAL RIGHTS.—

''(1) IN GENERAL.—

''(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

''(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

''(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

''(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

''(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

''(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

''(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

''(D) TIME LIMITS FOR APPEALS.—

''(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described subparagraph (A) files notice with the Secretary to request reconsideration by not later than 180 days after the individual receives notice of the initial determination under subsection (a) or within such additional time as the Secretary may allow.

''(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

''(E) AMOUNTS IN CONTROVERSY.—

''(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

''(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow 2 or more appeals to be aggregated if the appeals involve—

''(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

''(II) common issues of law and fact arising from services furnished to 2 or more individuals by one or more providers of services or suppliers.

''(F) EXPEDITED PROCEEDINGS.—

''(i) EXPEDITED DETERMINATION.—In the case of an individual who—

''(I) has received notice by a provider of services that the provider of services plans to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

''(II) has received notice by a provider of services that the provider of services plans to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

''(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

''(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

''(2) REVIEW OF COVERAGE DETERMINATIONS.—

''(A) NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

''(I) Such a determination shall not be reviewed by any administrative law judge.

''(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

''(III) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(IV) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(ii) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Secretary respecting whether or not a particular item or service is covered nationally under this title, including such a determination under 1862(a)(1).

''(B) LOCAL COVERAGE DETERMINATION.—In the case of a local coverage determination made by a fiscal intermediary or a carrier under part A or part B respecting whether a particular type or class of items or services is covered under such parts, the following limitations apply:

''(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(ii) Such a determination may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(C) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of review of a determination under subparagraph (A)(i)(III) or (B)(i) where the moving party alleges that there are no material issues of fact in dispute, and alleges that the only issue is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction.

''(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

''(I) Issue a national coverage determination, with or without limitations.

''(II) Issue a national noncoverage determination.

''(III) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

''(IV) Issue a notice that states that the Secretary has not completed a review of the request

for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

''(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

''(iii) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

''(E) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations.

''(ii) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

''(3) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

''(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

''(5) STANDING.—An action under this section seeking review of a coverage determination (with respect to items and services under this title) may be initiated only by one (or more) of the following aggrieved persons, or classes of persons:

''(A) Individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

''(B) Persons, or classes of persons, who make, manufacture, offer, supply, make available, or provide such items and services.

''(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under paragraphs (2) and (3) of subsection (a). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

''(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term 'qualified independent contractor' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a), and that meets the requirements established by the Secretary consistent with paragraph (3).

''(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the following requirements:

''(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required under regulations of the Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

''(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

''(i) such payment is allowed by reason of section 1879;

''(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

''(iii) such determination is changed as the result of any hearing by the Secretary or judicial review of the decision under this section; or

''(iv) such payment is authorized under section 1861(v)(1)(G).

''(C) DEADLINES FOR DECISIONS.—

''(i) DETERMINATIONS.—The qualified independent contractor shall conduct and conclude a determination under subparagraph (B) or an appeal of an initial determination, and mail the notice of the decision by not later than the end of the 45-day period beginning on the date a request for reconsideration has been timely filed.

''(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i), the party requesting the reconsideration or appeal may request a hearing before an administrative law judge, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

''(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or in accordance with the following:

''(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j), not later than 1 day after the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

''(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

''(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

''(i) PHYSICIANS.—No physician under the employ of a qualified independent contractor may review—

''(I) determinations regarding health care services furnished to a patient if the physician was directly responsible for furnishing such services; or

''(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the physician's family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

''(ii) PHYSICIAN'S FAMILY DESCRIBED.—For purposes of this paragraph, a physician's family includes the physician's spouse (other than a spouse who is legally separated from the physician under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents.

''(E) EXPLANATION OF DETERMINATIONS.—Any determination of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the determination as well as a discussion of the pertinent facts and applicable regulations applied in making such determination.

''(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

''(G) DISSEMINATION OF INFORMATION.—Each qualified independent contractor shall, using the methodology established by the Secretary under subsection (d)(4), make available all determinations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, and other entities under contract with the Secretary to make initial determinations under part A or part B or title XI.

''(H) ENSURING CONSISTENCY IN DETERMINATIONS.—Each qualified independent contractor shall monitor its determinations to ensure the consistency of its determinations with respect to requests for reconsideration of similar or related matters.

''(I) DATA COLLECTION.—

''(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

''(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

''(I) Specific claims that give rise to appeals.

''(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

''(III) Situations suggesting the need for changes in national or local coverage policy.

''(IV) Situations suggesting the need for changes in local medical review policies.

''(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

''(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the Secretary for a hearing, including as necessary, explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

''(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

''(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

''(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

''(A) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall promulgate regulations governing the processes of reconsiderations of determinations by the Secretary and qualified independent contractors and of hearings by the Secretary. Such regulations shall include such specific criteria and provide such guidance as required to ensure the adequate functioning of the reconsiderations and hearings processes and to ensure consistency in such processes.

''(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

''(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

''(II) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

''(II) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subclause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

''(ii) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (B) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

''(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

''(iv) DAB HEARING PROCEDURE.—In the case of a request described in clause (iii), the Departmental Appeals Board shall review the case de novo.

''(C) POLICIES.—The Secretary shall provide such specific criteria and guidance, including all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

''(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

''(E) EFFECT OF FAILURE TO PUBLISH POLICIES.—

''(i) NATIONAL AND LOCAL COVERAGE POLICIES.—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

''(ii) OTHER POLICIES.—With respect to policies established by the Secretary other than the policies described in clause (i), qualified independent contractors shall not be bound by such policies if the Secretary does not furnish to the qualified independent contractor the policies in a published format consistent with subparagraph (C).

''(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—

''(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

''(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and, in consultation with the Commissioner of Social Security, administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight may not be delegated to regional offices of the Department.

''(4) DISSEMINATION OF DETERMINATIONS.—The Secretary shall establish a methodology under which qualified independent contractors shall carry out subsection (c)(3)(G).

''(5) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

''(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.''.

(b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO MEDICARE+CHOICE INDEPENDENT APPEALS CONTRACTORS.—Section 1852(g)(4) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at the end the following: ''The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.''.

(c) CONFORMING AMENDMENT TO REVIEW BY THE PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g)) is amended by adding at the end the following new paragraph:

''(3) Findings described in paragraph (1) and determinations and other decisions described in paragraph (2) may be reviewed or appealed under section 1869.''.

SEC. 222. PROVISIONS WITH RESPECT TO LIMITATIONS ON LIABILITY OF BENEFICIARIES.

(a) EXPANSION OF LIMITATION OF LIABILITY PROTECTION FOR BENEFICIARIES WITH RESPECT TO MEDICARE CLAIMS NOT PAID OR PAID INCORRECTLY.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsections:

''(i) Notwithstanding any other provision of this Act, an individual who is entitled to benefits under this title and is furnished a service or item is not liable for repayment to the Secretary of amounts with respect to such benefits—

''(1) subject to paragraph (2), in the case of a claim for such item or service that is incorrectly paid by the Secretary; and

''(2) in the case of payments made to the individual by the Secretary with respect to any claim under paragraph (1), the individual shall be liable for repayment of such amount only up to the amount of payment received by the individual from the Secretary.

''(j)(1) An individual who is entitled to benefits under this title and is furnished a service or item is not liable for payment of amounts with respect to such benefits in the following cases:

''(A) In the case of a benefit for which an initial determination has not been made by the Secretary under subsection (a) whether payment may be made under this title for such benefit.

''(B) In the case of a claim for such item or service that is—

''(i) improperly submitted by the provider of services or supplier; or

''(ii) rejected by an entity under contract with the Secretary to review or pay claims for services and items furnished under this title, including an entity under contract with the Secretary under section 1857.

''(2) The limitation on liability under paragraph (1) shall not apply if the individual signs a waiver provided by the Secretary under subsection (l) of protections under this paragraph, except that any such waiver shall not apply in the case of a denial of a claim for noncompliance with applicable regulations or procedures under this title or title XI.

''(k) An individual who is entitled to benefits under this title and is furnished services by a provider of services is not liable for payment of amounts with respect to such services prior to noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under

paragraph (1), unless the following conditions are met:

''(1) The provider of services shall furnish a notice of discharge and appeal rights established by the Secretary under subsection (l) to each individual entitled to benefits under this title to whom such provider of services furnishes services, upon admission of the individual to the provider of services and upon notice of determination to discharge the individual from the provider of services, of the individual's limitations of liability under this section and rights of appeal under section 1869.

''(2) If the individual, prior to discharge from the provider of services, appeals the determination to discharge under section 1869 not later than noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), the provider of services shall, by the close of business of such first working day, provide to the Secretary (or qualified independent contractor under section 1869, as determined by the Secretary) the records required to review the determination.

''(l) The Secretary shall develop appropriate standard forms for individuals entitled to benefits under this title to waive limitation of liability protections under subsection (j) and to receive notice of discharge and appeal rights under subsection (k). The forms developed by the Secretary under this subsection shall clearly and in plain language inform such individuals of their limitations on liability, their rights under section 1869(a) to obtain an initial determination by the Secretary of whether payment may be made under part A or part B for such benefit, and their rights of appeal under section 1869(b), and shall inform such individuals that they may obtain further information or file an appeal of the determination by use of the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) maintained by the Secretary. The forms developed by the Secretary under this subsection shall be the only manner in which such individuals may waive such protections under this title or title XI.

''(m) An individual who is entitled to benefits under this title and is furnished an item or service is not liable for payment of cost sharing amounts of more than $50 with respect to such benefits unless the individual has been informed in advance of being furnished the item or service of the estimated amount of the cost sharing for the item or service using a standard form established by the Secretary.''.

(2) CONFORMING AMENDMENT.—Section 1870(a) of the Social Security Act (42 U.S.C. 1395gg(a)) is amended by striking ''Any payment under this title'' and inserting ''Except as provided in section 1879(i), any payment under this title''.

(b) INCLUSION OF BENEFICIARY LIABILITY INFORMATION IN EXPLANATION OF MEDICARE BENEFITS.—Section 1806(a) of the Social Security Act (42 U.S.C. 1395b–7(a)) is amended—

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

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) lists with respect to each item or service furnished the amount of the individual's liability for payment;'';

(4) in paragraph (3), as so redesignated, by striking the period at the end and inserting ''; and''; and

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

''(4) includes the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) for information and questions concerning the statement, liability of the individual for payment, and appeal rights.''.

SEC. 223. WAIVERS OF LIABILITY FOR COST SHARING AMOUNTS.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amended by striking clauses (i) through (iii) and inserting the following:

''(i) the waiver is offered as a part of a supplemental insurance policy or retiree health plan;

''(ii) the waiver is not offered as part of any advertisement or solicitation, other than in conjunction with a policy or plan described in clause (i);

''(iii) the person waives the coinsurance and deductible amount after the beneficiary informs the person that payment of the coinsurance or deductible amount would pose a financial hardship for the individual; or

''(iv) the person determines that the coinsurance and deductible amount would not justify the costs of collection.''.

(b) CONFORMING AMENDMENT.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) In this section, the term 'remuneration' includes the meaning given such term in section 1128A(i)(6).''.

SEC. 224. ELIMINATION OF MOTIONS BY THE SECRETARY ON DECISIONS OF THE PROVIDER REIMBURSEMENT REVIEW BOARD.

Section 1878(f)(1) of such Act (42 U.S.C. 1395oo(f)(1)) is amended—

(1) in the first sentence, by striking ''unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision'';

(2) in the second sentence, by striking '', or of any reversal, affirmance, or modification by the Secretary,'' and ''or of any reversal, affirmance, or modification by the Secretary''; and

(3) in the fifth sentence, by striking ''and not subject to review by the Secretary''.

SEC. 225. EFFECTIVE DATE OF SUBTITLE.

In no case shall the amendments made by this subtitle apply before October 1, 2000.

TITLE III—MEDICARE+CHOICE REFORMS; PRESERVATION OF MEDICARE PART B DRUG BENEFIT

Subtitle A—Medicare+Choice Reforms

SEC. 301. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0 percentage points''.

SEC. 302. PERMANENTLY REMOVING APPLICATION OF BUDGET NEUTRALITY BEGINNING IN 2002.

Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), in the matter following clause (ii), by inserting ''(for years before 2002)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(before 2002)'' after ''for each year''.

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853(c)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is amended—

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

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

''(II) For 2002 for any of the 50 States and the District of Columbia, $450.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to years beginning with 2002.

SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

(a) IN GENERAL.—Section 1853(c)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking ''(ii) For a subsequent year'' and inserting ''(ii)(I) Subject to subclause (II), for a subsequent year''; and

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

''(II) During 2002, 2003, 2004, and 2005, in the case of a Medicare+Choice payment area in which there is no more than 1 contract entered into under this part as of July 1 before the beginning of the year, 102.5 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(b) CONSTRUCTION.—The amendments made by subsection (a) do not affect the payment of a first time bonus under section 1853(i) of the Social Security Act (42 U.S.C. 1395w–23(i)).

SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN CERTAIN MEDICARE+CHOICE PAYMENT AREAS BELOW NATIONAL AVERAGE.

Section 1853(c)(1) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(1) in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''; and

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

''(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

''(i) IN GENERAL.—For each year beginning with 2004, in the case of a Medicare+Choice payment area for which the Medicare+Choice capitation rate under this paragraph would otherwise be less than the United States per capita cost (USPCC), as calculated by the Secretary, a Medicare+Choice organization may negotiate with the Medicare Benefits Administrator an annual per capita rate that—

''(I) reflects an annual rate of increase up to the rate of increase specified in clause (ii);

''(II) takes into account audited current data supplied by the organization on its adjusted community rate (as defined in section 1854(f)(3)); and

''(III) does not exceed the United States per capita cost, as projected by the Secretary for the year involved.

''(ii) MAXIMUM RATE DESCRIBED.—The rate of increase specified in this clause for a year is the rate of inflation in private health insurance for the year involved, as projected by the Medicare Benefits Administrator, and includes such adjustments as may be necessary—

''(I) to reflect the demographic characteristics in the population under this title; and

''(II) to eliminate the costs of prescription drugs.

''(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.''.

SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED ON DATA FROM ALL SETTINGS.

Section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

''and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the

methodology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.''.

SEC. 308. DELAY FROM JULY TO OCTOBER, 2000 IN DEADLINE FOR OFFERING AND WITHDRAWING MEDICARE+CHOICE PLANS FOR 2001.

Notwithstanding any other provision of law, the deadline for a Medicare+Choice organization to withdraw the offering of a Medicare+Choice plan under part C of title XVIII of the Social Security Act (or otherwise to submit information required for the offering of such a plan) for 2001 is delayed from July 1, 2000, to October 1, 2000, and any such organization that provided notice of withdrawal of such a plan during 2000 before the date of the enactment of this Act may rescind such withdrawal at any time before October 1, 2000.

Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including injectable and infusable drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

SEC. 312. GAO REPORT ON PART B PAYMENT FOR DRUGS AND BIOLOGICALS AND RELATED SERVICES.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study to quantify the extent to which reimbursement for drugs and biologicals under the current medicare payment methodology (provided under section 1842 (o) of the Social Security Act (42 U.S.C. 1395u(o)) overpays for the cost of such drugs and biologicals compared to the average acquisition cost paid by physicians or other suppliers of such drugs

(b) ELEMENTS.—The study shall also assess the consequences of changing the current medicare payment methodology to a payment methodology that is based on the average acquisition cost of the drugs. The study shall, at a minimum, assess the effects of such a reduction on—

(1) the delivery of health care services to Medicare beneficiaries with cancer;

(2) total Medicare expenditures, including an estimate of the number of patients who would, as a result of the payment reduction, receive chemotherapy in a hospital rather than in a physician's office;

(3) the delivery of dialysis services;

(4) the delivery of vaccines;

(5) the administration in physician offices of drugs other than cancer therapy drugs; and

(6) the effect on the delivery of drug therapies by hospital outpatient departments of changing the average wholesale price as the basis for Medicare pass-through payments to such departments, as included in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(c) PAYMENT FOR RELATED PROFESSIONAL SERVICES.—The study shall also include a review of the extent to which other payment methodologies under part B of the medicare program, if any, intended to reimburse physician and other suppliers of drugs and biologicals described in subsection (a) for costs incurred in handling, storing and administering such drugs and biologicals are inadequate to cover such costs and whether an additional payment would be required to cover these costs under the average acquisition cost methodology.

(d) CONSIDERATION OF ISSUES IN IMPLEMENTING AN AVERAGE ACQUISITION COST METHODOLOGY.—The study shall assess possible means by which a payment method based on average acquisition cost could be implemented, including at least the following:

(1) Identification of possible bases for determining the average acquisition cost of drugs, such as surveys of wholesaler catalog prices, and determination of the advantages, disadvantages, and costs (to the government and public) of each possible approach.

(2) The impact on individual providers and practitioners if average or median prices are used as the payment basis.

(3) Methods for updating and keeping current the prices used as the payment basis.

(e) COORDINATION WITH BBRA STUDY.—The Comptroller General shall conduct the study under this section in coordination with the study provided for under section 213(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A-350), as enacted into law by section 1000(a)(6) of Public Law 106-113.

(f) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General shall submit a report on the study conducted under this section, as well as the study referred to in subsection (e). Such report shall include recommendations regarding such changes in the medicare reimbursement policies described in subsections (a) and (c) as the Comptroller General deems appropriate, as well as the recommendations described in section 213(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

The SPEAKER pro tempore. The gentleman from Texas (Mr. ARCHER), the gentleman from New York (Mr. RANGEL), the gentleman from Virginia (Mr. BLILEY), and the gentleman from Michigan (Mr. DINGELL) each will control 30 minutes.

The Chair recognizes the gentleman from Texas (Mr. ARCHER).

GENERAL LEAVE

Mr. ARCHER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 4680.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. ARCHER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today 12 million seniors and disabled Americans on Medicare, including 7 million women, have no prescription drug coverage. For the vast majority of seniors living on fixed incomes, this is a very difficult situation. This bill brings them help.

Clearly, Mr. Speaker, now is the time for us to add to Medicare prescription drug coverage. Our Republican bipartisan plan does just that. 5.5 million low-income seniors, almost half of those on Medicare today, are without coverage. They now will have a prescription drug plan. For about the cost of a movie ticket, those seniors will be able to get the medicines that they need, no matter the cost, no matter the illness.

We do not just cover low-income Americans. We cover every senior who wishes to enroll. Seniors will be given the right to choose, the right to voluntarily choose the drug plan that works best for them. They will receive a 25 percent reduction in the price of the drugs they buy and the security also of catastrophic coverage in the case of chronic illness or excessively high drug costs.

So all 6½ million middle-income seniors without coverage will also get to choose a prescription drug benefit plan as well. This is truly a complete package, but there are some things that our plan will not do. First, it will not affect the millions of seniors who have existing drug coverage and like it. They will be able to continue with that.

Second, it will not force seniors into a bureaucratic government-run plan that dictates what drugs seniors can and cannot have.

Third, it will not evaporate over time if drug costs continue to outpace inflation.

Finally, it will not break the bank or threaten Medicare's future.

All of these items that I mentioned are concerns that we have with the Democrat plan. Democrats will offer seniors no choice. They offer seniors only a single government-run plan, and seniors will have to take it or leave it.

Finally, the Democrat plan makes seniors wait until the year 2006, 6 years from now, before they can get catastrophic coverage and then only if Washington has a surplus.

Why the delay? Why the contingency? The Democrat plan is a big step toward Washington-run health care but a step backward in helping seniors with the high cost of prescription drugs.

Our Republican bipartisan bill, by contrast, gives seniors the right to choose the coverage that works best for them. It gives seniors a 25 to 39 percent discount off the price of their drugs.

This vote is a simple choice, Mr. Speaker. I urge my colleagues to vote for the Republican bipartisan bill that makes prescription drugs available, affordable and voluntary.

Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, every time there is a good idea that we have in this House of Representatives, the Republican majority has to figure some way to find some wording that either it is going to be deep-sixed and never be brought to the floor or that it becomes a political statement because they can be assured that it is going to be vetoed. It is not only affordable health care. Whether it is school construction, minimum wage, gun safety, patient bill of rights, all good ideas, but they have to find some way to make certain that it never becomes the law; that they have to challenge Democrats and challenge the President.

They keep calling this a bipartisan bill because they found a Democrat or two that lost their way. The truth of the matter is, bipartisanship starts

with the committee. The gentleman from Texas (Mr. ARCHER) is supposed to talk with the gentleman from New York (Mr. RANGEL) and say, hey, can we get a bipartisan bill? The gentleman from California (Mr. THOMAS) is supposed to talk to the gentleman from California (Mr. STARK) and say, hey, can we work out something? That is how we get bipartisanship. That is historically how we do it here.

But, no, what the other side has chosen to do is to wait until 2:00 or 3:00 in the morning and decide that we are not going to have any option. It is going to be the Republican way or no way.

One of my favorite Republicans once said, if one gets a telephone call at 2:30 in the morning, it must be suspicious, that something is going wrong. Well, if one gets it at 3:00 in the morning, then they can rest assured that something is going on that they do not want the American people to know.

What is it? That they have a bill, they have a statement. We do not challenge the fact that they just do not like government helping people. That is their way. That is how they think. If it is Social Security, if it is Medicare, if it is education, privatize it and forget it. Get some vouchers, let the private sector do it. Give the money to the HMOs, give it to the insurers because they cannot trust old folks with their own prescription drugs.

All we are asking for is a chance to have another way. So I can say this, it is possible that the voters were sleeping when the Republicans had concocted this scheme to deny us an option to really provide health care for those who need it, but I assure them that when they vote today that the voters will not be sleeping when they check out the voting records as to who really was concerned about affordable health care. Even those that they want to help reject this cockamamie scheme that they can feed money into the HMO and that they are going to now go into the rural areas and provide health care.

Mr. Speaker, I ask unanimous consent to yield the remainder of my time to the gentleman from California (Mr. STARK), the ranking member of the Subcommittee on Health, so that he may designate and yield to other Members of the House.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. ARCHER. Mr. Speaker, I yield 1¼ minutes to the gentleman from Missouri (Mr. HULSHOF), the respected member of the Committee on Ways and Means.

(Mr. HULSHOF asked and was given permission to revise and extend his remarks.)

Mr. HULSHOF. Mr. Speaker, talk is cheap. Prescription drugs are not. They are expensive and getting more expensive every day. Seniors need help now. The competing plans are alike in certain respects, monthly premiums, deductibles, out-of-pocket costs, taking care of low-income seniors; but I agree with the gentleman who just spoke that there are some philosophical differences between the two plans. In other words, shall seniors have a right to choose or shall America's seniors be forced to lose? That is what is at stake. Do we trust older Americans to be able to choose for themselves the prescription drug plans and let them keep the plans that they like? Or shall we force them into a take-it-or-leave-it approach? I think we should trust those in their golden years to make those decisions for themselves.

We have seen health-run plans in other nations, and we have seen they have not worked. In Canada and England they are not on the cutting edge of having miracle drug therapies; or the fact that seniors cannot get prescription drugs, have their doctors prescribe them and then get those drugs as they need it.

When Medicare began in 1965, the corner drugstore was the gathering place. People would sit around and catch up. Pharmacists would know a person's name, know their medical history. That has not changed even though the country has. Under our plan, that will not change, except that prescription medicines will be cheaper.

I urge a yes vote on the bipartisan plan.

Mr. STARK. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, to the previous speaker in the well I would say things have not changed, or maybe they have. Now the lobbyists for the pharmacists get together with Members of Congress in the dead of night and draw a bill that will benefit only the pharmaceutical corporations and the managed care companies. So where we used to be able to consult with our local pharmacist about what is good for us, now we have to let the Republicans cozy up to the lobbyists in whose pocket they reside and get their campaign contributions and whatever other gifts they want to give them as they draft a bill which will only help the pharmaceutical industry and the HMOs in this country.

I would like to say that the Democrats' bill, if it were allowed to be voted on by the Republicans, is a better bill. We will hear in the debate that there are some similarities, and there are. The principal difference is that the Democrats bill is dependable. It uses real resources, and it is an integral part of Medicare.

The Republican bill will never come into law. We see before us the statement that was given to us this morning by the administration which opposes H.R. 4680 because its private insurance benefit does not meet the President's test of being a meaningful Medicare prescription drug benefit that is affordable and accessible for all beneficiaries; and if H.R. 4680 were presented to the President, he would veto it.

So we are today debating something that will never come to pass, and we have been foreclosed from offering an option. Admittedly, the option would be much more expensive, and we are proud of that. We, in our limited bill, have half the number of uninsured seniors than the Republicans do. If the Republican bill were to pass, which is not likely, there would still be 10 million Medicare beneficiaries without any health care.

Our bill would leave 4½ million Medicare beneficiaries, half as few, that would not have insurance. Yet we are begging to spend this surplus and not waste it on a relief from the inheritance tax, which will benefit 3,000 or 4,000 of the very richest Americans. With that money alone, we could provide an added benefit at a low enough premium and eliminate the copay so that we could include all the Medicare beneficiaries in a generous, dependable benefit with a reliable premium that would be the same across the country and allow the seniors to get their drugs from any provider in the country. This is not true under the Republican bill.

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We think that the government can do a better job than subsidizing managed care drug plans whose record has been to increase the premiums, leave the program, abandon their beneficiaries, kick up the premiums, cut benefits, where Medicare has done none of that, it has been dependable. I wish we could bring our bill to the public.

Mr. Speaker, I reserve the balance of my time.

Mr. ARCHER. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania, (Mr. ENGLISH), another respected member of the Ways and Means Committee.

Mr. ENGLISH. Mr. Speaker, if we can set aside for a moment the hot bipartisan rhetoric, today the House has an opportunity to take a historic step to ensure that no senior will ever have to face the choice again between destitution and neglecting their prescriptions.

The House bipartisan prescription drug plan is a balanced, market-oriented approach targeted to updating Medicare and providing prescription coverage, more generous coverage as it happens than what the President has originally proposed.

For my district, the plan does some very important things. It takes vital steps toward improving Medicare as a whole. It expedites the appeals process by mandating Medicare appeals. They used to take an average of 400 days now it takes less than a quarter of that time.

Our plan is the only one that addresses the problems in Medicare+Choice, particularly a problem in portions of my district, where plans are raising rates or cutting benefits.

Under our bipartisan bill, we move the prescription drug benefit of Medicare+Choice out from under the cold shadow of the Health Care Financing Administration that has haunted the program, instead we create the

Medicare Benefit Administration to safeguard prescription drug plans and negotiate lower prescription prices for seniors.

Mr. Speaker, today the House takes a historic step to ensure that no senior will ever have to face the choice between destitution and prescription drugs. The House Bipartisan Prescription Drug Plan is available, affordable and voluntary for ALL seniors.

Under this proposal, seniors will no longer have to pay exorbitant prices for drugs. Using group bargaining power, seniors will enjoy a 25 percent discount on necessary prescriptions.

Many seniors in my district will qualify for direct subsidies. About 100,000 seniors in Pennsylvania will be covered 100 percent under this plan.

But the best part is that those seniors who are struggling to pay runaway drug costs would have access to a Medicare entitlement which covers all of their costs about $6,000.

Seniors at all income levels will have access to affordable prescription drug coverage that best meets their individual needs.

The House Bipartisan Prescription Drug Plan is a balanced, market-oriented approach targeted at updating Medicare and providing prescription drug coverage.

Under our prescription drug plan, the government would share in insuring the sickest seniors, making the risk more manageable for private insurers.

By sharing the risk and the cost associated with caring for the sickest beneficiaries, premiums will be lower for every beneficiary.

Keeping rural seniors in mind, our plan guarantees at least two drug plans will be available in every area of the country with the government serving as the insurer of last resort.

The President's plan shoehorns seniors—many of whom have private drug coverage which they are happy with—into what I call a ''one-size-fits-few'' plan with Washington bureaucrats in control of their benefits.

MEDICARE REFORMS

The plan takes vital steps toward improving Medicare as a whole. It expedites the appeals process by mandating that appeals that used to take an average of 400 days now take less than a quarter of that time.

Our plan is the only one that addresses the problems of Medicare+Choice. In portions of my district, plans are raising rates and cutting benefits to seniors because the dismal reimbursement rates.

We move the prescription drug benefit and Medicare+Choice out from under the cold shadow of the Health Care Financing Administration that has haunted and nearly bankrupted the system.

The Medicare Benefit Administration will be created to safeguard prescription drug plans and negotiate lower prescription prices for seniors. The administration will allow the plan to realize its potential, free from interference from the bureaucracy.

We further strengthen Medicare+Choice plans by: raising the base rate that counties currently receive; providing higher updates for those areas who currently have 1 or no plans—thereby encouraging plans to continue to provide coverage in these areas.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Washington State (Mr. MCDERMOTT), who knows why the National Committee to Preserve Social Security and Medicare and National Council on Aging supports the Democrats' plan and opposes the Republicans' plan.

Mr. MCDERMOTT. Mr. Speaker, this bill is like a bad April Fool's Day joke. You know there is a purse that is laying out on the street with a string on it. And the person comes along and pulls the string and the people keep reaching for it and they cannot quite get it.

The Republican bill has no guaranteed premium in it. It has no guaranteed costs reduction in it. I do not care what figures they throw around out here, 25 percent to 39 percent reduction, it is not in the bill. There is no assurance of two choices.

One Republican Member let the cat out of the bag, it may be enough just to introduce a bill, but if we don't even have a bill, we are open to charges that we didn't do anything. That tells us where they really are, and it also tells us what their consultant told them.

He said, it is more important to communicate that you have a plan as it is to communicate what is in the plan. The reason this was done at night, the reason they will not allow us to make an alternative, the reason they do not want any open debate is because they do not want to communicate to anybody until they put out those commercials in the election.

They will say we passed a bipartisan bill for seniors with a couple of Democrats and a joke in terms of how it works. In this bill, we ask ourselves, where are they going to get the two plans that they talk about?

The bill says on one page, we will subsidize up to 35 percent. What if nobody will take it at 35 percent, they hold out. The bill later says they can add incentives and the chairman of the subcommittee said in the committee room that you could subsidize up to 99 percent.

If there is an insurance company out there that can get 99 percent subsidy on the plan maybe they will offer it, but I am telling my colleagues it is going to cost the American people. It is a bad bill.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from Minnesota (Mr. PETERSON), someone who believes in policy over politics.

Mr. PETERSON of Minnesota. Mr. Speaker, I thank the gentleman for yielding to me. He and I have been working together on one aspect of this Medicare problem that I have depicted in this chart here, and that is the fact that we have 3,025 counties in this country that are being paid below the average of the normal reimbursement, and 168 counties that are being paid above.

I am going to say something that I have heard a lot of my colleagues say, but I do not think very many people are going to dare say on the floor of this House, and, that is, that it is irresponsible for us to be providing a drug benefit without reforming this system. And where I am coming from with this issue is that I think if we add a drug benefit, such as my friends on the Democratic side, on top of the existing system, the chances of us ever getting this fixed are going to be almost zero.

What has happened since we started work on this in 1995 in Dade County, which started off at $620 a month reimbursement, they are now up to $809 a month. In my area, we had $239 reimbursements, we raised that floor to $375, and it has stuck there ever since.

Since 1997, what has happened, Dade County has gone up 8 percent, we are still at $375; and the problem I have with this whole thing is that we cannot set another benefit where we are going to have the Government pick up 100 percent of these benefits, that nobody else is at risk except the government and think we are going to have the money available to fix this plan.

Mr. Speaker, at least on this side, the gentleman from California (Mr. THOMAS) and others have come forward and tried to address this issue, have funded the blend, have raised the cap and then after we got done with that, then the administration and my friends on this side of the aisle came along and said, well, we will do the same thing on our bill.

I have not seen a lot of interest, unfortunately, on my side of the aisle dealing with this problem, but this map shows where in this country they have zero premium plans or drug coverage, the dark areas are those areas, the whole rest of this is the area where they are not getting this kind of coverage. I would argue with the Democratic plan, they will never get it.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. KLECZKA), a distinguished member of the Subcommittee on Health of the Committee on Ways and Means, who understands that Families USA and the Leadership Council of Aging organizations vehemently oppose the Republican bill and support the Democratic substitute.

Mr. KLECZKA. Mr. Speaker, I am trying to figure out what the previous speaker said. He is the one supporting the Republican drug bill, and as I recall, he said it is irresponsible for us to provide a drug benefit at this time. Nevertheless, he signs on to the Republican drug benefit bill. That tells me, and he is a pretty honest guy, that their bill does not provide a drug benefit at all. I agree with that.

Mr. Speaker, the Republican drug bill is a cruel hoax and an empty promise to our senior citizens. We are going to end up passing their bill today, and we are going to go home for the 4th of July break. I challenge the senior citizens in their districts to ask a few questions. My friends here is a copy of the bill, I challenge constituents to say, Mr. Republican Congressman, where in the bill is the premium that I am going to be charged? They are

going to say well, it is not in there. I will be darned.

Mr. Republican Congressman, what are the drugs covered? Where is the listing of the drugs? It is not in here. Well, Mr. Republican Congressman, how about the deductibles and copays; is that in there? No, that is not in there either.

The constituent will say, what kind of bill is this? They will say we are going to hire a new bureaucrat for $140,000 a year who will work with the insurance companies to make those decisions.

Our bill is voluntary, defines a premium of $25 a month. In the Republican bill insurance companies will decide that with this new bureaucrat. That is a drug benefit? That is a farce. This bill does not provide a universal program, where doctors coverage for Medicare is the same in this part of the country as in that part. This bill hopes and prays that the insurance companies will offer it.

Mr. Speaker, if this type of policy was profitable for insurance companies, they would offer it today. They are not going to do this. This bill is going to fail.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Illinois (Mr. WELLER), a member of the Ways and Means Committee.

(Mr. WELLER asked and was given permission to revise and extend his remarks.)

Mr. WELLER. Mr. Speaker, over the last several years, as I have represented the South Side of Chicago and the south suburbs, I have often been asked the question should our senior citizens today have to make a choice between buying lunch or dinner or paying for their prescription drugs?

Today we are answering that question with bipartisan legislation to ensure that seniors no longer have to make that choice between paying for their prescription drugs or paying for lunch or breakfast or dinner. We have a bipartisan plan that is now before us that is available for every senior. If you qualify for Medicare under this bipartisan plan, you qualify for prescription drug coverage. It is affordable.

If you have prescription drug coverage today, another benefit is we let you keep it; if your retirement has good coverage, you do not have to worry about losing, because it is covered by Medicare as well. It is also voluntary, which means if you like what you have, you do not have to take it.

We have the security of insuring that if you have a catastrophic situation, of course, that is covered as well. The bottom line is it is a bipartisan plan. It is affordable. There are choices, and it is secure for every senior.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Wisconsin (Mr. OBEY), the former chairman of the Committee on Appropriations, who understands that the National Council of Senior Citizens and the National Senior Citizens Law Center both oppose the Republican plan and wholeheartedly endorses the Democratic plan.

Mr. OBEY. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, the drug companies vigorously support the Republican plan, because they understand that the Republican plan is like the wolf giving Little Red Riding Hood a roadmap through the woods. It is a phony deal.

The Republican leadership says we can afford to provide $200 billion in tax cuts to the wealthiest 400 people in this country. They say we can afford to provide $90 billion in tax cuts to the wealthiest 1 percent who make more than $300,000 a year, but somehow we cannot afford to provide a real affordable prescription drug benefit for every senior citizen under Medicare.

Under the Republican approach, they simply privatize Medicare, because they do not have the guts to let us vote on a real plan, because they know if they did, they would lose.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Illinois (Mr. Crane), a valued member of the Ways and Means Committee, the chairman of the Subcommittee of Trade, a member of the Subcommittee on Health.

Mr. CRANE. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I want to take this opportunity to share with my colleagues my strong support for this legislation, H.R. 4680, the Medicare Rx 2000 Act.

Medicare was facing insolvency in the year 2002 when Republicans took control of the House in January 1995. As a result of our hard work, and despite false charges from those on the other side of the aisle about our intent, the Medicare Trust Fund is now solvent until 2025.

Nearly every Member on our side of the aisle voted for the fiscal year 2001 budget resolution that set aside $40 billion over the next 5 years for a Medicare prescription drug benefit because we recognized the need to modernize and strengthen Medicare for the 21st century.

Speaker Hastert then formed a working group to write a Medicare prescription drug plan within the budget guidelines. To the credit of Subcommittee on Health chairman, the gentleman from California (Mr. THOMAS); Committee on Commerce chairman, the gentleman from Virginia (Mr. BLILEY); and other Members of the working group, a market-based approach was drafted to provide a Medicare prescription drug benefit that is voluntary, affordable and available to all senior citizens.

Mr. Speaker, I urge my colleagues to support this bill.

Mr. Speaker, the plan is so well drafted it has gained bipartisan support. Unfortunately, many of my friends in the minority are supporting a government-run, take it or leave it, one-size fits all program that will cost hundreds of billions of dollars. That plan would also force millions of seniors to give up the private coverage they now have.

This bipartisan legislation provides seniors with a voluntary program, under which they would have several options and could choose which plan fits their individual needs best. This legislation also provides for coverage for seniors with unusually high drug costs. For seniors with unusually high drug costs, the plan provides security by covering 100 percent of out-of-pocket costs beyond $6,000.

I strongly urge you to support the Medicare Rx 2000 Act. I am well aware that some may think another approach might work better and others are concerned about the budget impact of adding a prescription drug benefit to Medicare. As a member of the Ways and Means Health Subcommittee, I can assure you these are questions I have answered to my own satisfaction during consideration of this legislation.

The Congressional Budget Office is expected to score the legislation under the $40 billion level we have already set aside in this year's budget.

The fact remains that our nation's health care system has changed since Medicare was first created and, to be effective, Medicare must change too. We must modernize Medicare before the Baby Boom generation retires, and we must recognize that every individual has unique health care needs. This legislation makes Medicare more flexible to address the differing needs of seniors and recognizes the importance of both prevention and treatment. In the long term, this approach will save money because preventive medicine can delay or eliminate the need for hospitalization.

As a fiscal conservative, I strongly believe the Medicare Rx 2000 Act does an excellent job of providing senior citizens the prescription drug benefits they need without squandering our nation's budget surplus. It does so by relying on the free enterprise system that has served our country so well and by giving senior citizens the choices they demand at prices for prescription drugs they can afford.

Once again, I urge your support for the Medicare Rx 2000 Act. Let's give our nation's seniors the choices they deserve at prices they can afford.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. LEWIS), who understands that the Alzheimers' Association and Consumers Union both oppose the Republican plan and endorse the Democrats' plan. He understands the working group, who put this bill together for the Republicans, is mostly comprised of lobbyists for the pharmaceutical industry and the managed care industry.

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Mr. LEWIS of Georgia. Mr. Speaker, under the Republican plan, there is no defined benefit. There is no set premium. This is a scheme written by the insurance companies. The Republicans did not like Medicare back in 1965, and they do not like it now. Here they are, once again, trying to privatize prescription drugs for seniors, just like they tried to privatize Medicare. This is nothing but a scheme.

The Republican scheme requires low-income seniors to go to the State welfare office. Are my Republican sisters

and brothers suggesting that my 86-year-old mother go down to the welfare office to find out whether she can get her prescription medicine?

This is a sham. This is a shame, and this is a disgrace.

My Republican colleagues, on the other hand, would prefer to give the money away in tax breaks to the wealthy, rather than to offer a sensible and affordable prescription medicine benefit. The availability of prescription medicine should not depend on the size of one's wallet or one's ZIP code.

There is no room, but no room in here to play partisan politics. No person in the twilight of his or her life should not have to choose between putting food on the table and getting his or her blood pressure and heart medicine.

This is not just, this is not right, and this is not fair. We have a moral obligation, a mission, and a mandate to stand up for our seniors. Our seniors do not want a prescription drug benefit next year, our seniors want it now, and they deserve it now. We can do no less for the seniors of America.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD). The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the House.

Mr. THOMAS. Mr. Speaker, I yield 1 minute to the gentlewoman from Washington (Ms. DUNN), a member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, seniors are living longer because of innovative new treatments that extend and improve their quality of life. Unfortunately, many of these new treatments carry a cost that puts a huge burden on the shoulders of seniors who are living on fixed incomes. Today will ensure that low-income seniors no longer need to have to decide between purchasing drugs and buying food or paying for rent. This bill of ours will provide all seniors access to affordable prescription drug coverage that will limit their out-of-pocket payments.

In addition, for low-income seniors, the bill will provide drug coverage that is free of premiums, deductibles and copayments. Regardless of income, seniors will be able to have peace of mind that they will have access to a voluntary drug benefit plan.

More importantly, Mr. Speaker, we offer seniors a choice of selecting a drug plan that meets their individual needs. We leave the decisions in the hands of seniors, not in the hands of government bureaucrats. In this way, we can make sure that those who offer drug plans are accountable to seniors who can choose to vote with their feet.

Mr. Speaker, I urge passage of our bill.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Mrs. THURMAN), a member of the Subcommittee on Health of the Committee on Ways and Means, who twice offered an amendment to give seniors a discount on their pharmaceutical drugs at no cost to the Federal Government, only to see every Republican on the Committee on Ways and Means vote against her amendment.

Mrs. THURMAN. Mr. Speaker, I find it quite interesting that we are talking about an insurance plan. In this country, we already have these plans. We have Medigap plans, we have Medicare Choice. But the problem is, they failed; and yet this is what we have to vote on again today. That is why this is the hottest issue in the country.

Senior groups who have nothing to gain have written and talked to us about why they cannot support the bill in front of us. They do not have any politics in this game. They want a drug benefit. They want to have life-sustaining drugs available to them.

So listen to them. The Senior Citizens League says, ''After considerable study, the Medicare RX 2000 Act will do more harm than good to the people that it is intended to help.''

How about Families of USA? They said, ''This proposal has all the attributes of a mirage. It looks inviting from a distance, but once you get up close, you realize there is nothing there. What is more, consumers do not know what they will actually get out of this. The Republican proposal leaves the actual benefit undefined.''

How about the Older Women's League who actually says, ''the Republican prescription drug plan does not represent a defined benefit added to the Medicare program but, rather, a private insurance program.''

Or how about the National Committee to Preserve Social Security and Medicare. ''The congressional Republican plan for prescription drug coverage for senior citizens is not what the American people need or want,'' according to one of the country's leading citizens advocate groups.

Mr. Speaker, these are folks that have come to talk to us. These are the folks that are in my town hall meetings. These are the folks that have told me: we want a defined benefit; we want a Medicare benefit. We are tired of being switched from plan to plan. We are tired of seeing our prices go up, and we have no control over it. The only way we get this is to make sure it goes through Medicare.

Please vote against this bill. Give our seniors what they deserve, and that is prescription drugs that they can afford.

Mr. THOMAS. Mr. Speaker, I yield myself 10 seconds.

Just so that people understand, letters of support for H.R. 4680 have come in from a number of institutions. The American Cancer Research Institute, the Kidney Cancer Association, National Alliance for the Mentally Ill. There are a number of organizations that simply disagree with the gentlewoman.

Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut (Mrs. JOHNSON), a member of the Subcommittee on Health of the Committee on Ways and Means.

(Mrs. JOHNSON of Connecticut asked and was given permission to revise and extend her remarks.)

Mrs. JOHNSON of Connecticut. Mr. Speaker, this is a red letter day for seniors. It is just a red letter day. For the first time in history, out of this House is going to go legislation to provide prescription drug coverage for seniors across America, every village, every city. I am proud of that. This is not about insurance companies, and here is the proof.

In the Democrats' bill, they are going to use, and it says, ''or insurers.'' They are going to use insurers; we are going to use insurers. They are going to use pharmaceutical benefits managers; we are going to use pharmaceutical benefits managers. They are going to use pharmacy chains; we are going to use pharmacies. The difference is, they are going to use one. They are going to use one plan. Seniors will have no choice, one formulary. Seniors will have no choice. In that one formulary, they may have only one drug in each category. In our bill, they must have multiple drugs. In our bill, we guarantee that we will cover off-label uses. Sixty percent of cancer victims depend on off-label uses of drugs for their cure.

Mr. Speaker, our plan offers them not only prescription coverage, but choice and hope.

Mr. Speaker, today is a great day for our nation's seniors because today we are considering historic legislation that will expand Medicare to cover the rising cost of prescription drugs.

When Medicare was created in 1965, prescription drug coverage was not included because there were relatively few drugs available and the focus was on physician and hospital care.

Today, however, it's clear that you can't have modern health care without having access to lifesaving pharmaceuticals.

Thankfully, two-thirds of seniors have prescription drug coverage under other health plans, but 12 million have no coverage at all.

This is simply morally wrong in the world's most prosperous nation because no senior should have to choose between filling the prescription they need and putting food on the table.

So, today is truly a red letter day. We will pass a House Republican bill with bipartisan support to make prescription drug coverage a part of Medicare for all seniors in America, in every town and every city.

While some of my Democrat colleagues are dramatizing their opposition to this bill, I would remind those watching that if it weren't an election year, they'd be claiming victory. The similarities between the two proposals, ours and theirs, is striking and broad.

The AARP acknowledged this point in a letter that they sent to Congress yesterday. ''We are pleased that both the House Republican and Democratic bills include a voluntary prescription drug benefit in Medicare—a benefit to which every Medicare beneficiary is entitled. Further, both bills provide for a benefit that would be available in either fee-for-service or

managed care settings. And while there are differences, both bills describe the core prescription drug benefit in statute. These are important steps and represent real progress over the past year.'' Horace B. Deets, AARP, June 27.

In other words, our plan is universal, just like the President's.

Our plan is voluntary, just like the President's.

Our plan provides an entitlement under Medicare, just like the President's.

Our plan contracts with private health organizations, just like the President's.

And like Part B coverage for doctor services and diagnostic tests, it is funded with both premiums and government subsidies, just like the President's.

But our plan is unique in two important ways. It is the only plan—and was the first—to provide immediate protection for seniors from out-of-control drug costs. All seniors will get full coverage for their drugs when their spending reaches the catastrophic threshold. We included this provision in our legislation from the very beginning because we realized how important it is for seniors peace of mind and retirement security. The President's original proposal did not include catastrophic coverage. When he realized the importance of our provision, he added it. I am hopeful that his movement toward the Republicans on this issue is a signal that we can work together in a bipartisan way to provide seniors with prescription drug coverage this year.

The second unique aspect of the House Republican bill is that it guarantees every senior in America access to at least two prescription drug plans.

We know every senior has different health care needs, and therefore needs different plans to choose from.

But a choice of plans also assures an immediate 25% price discount; lowering prescription drug costs for our seniors, just as large employers lower drug costs for their employees through group purchasing power. In contrast, the President's proposal—because it offers only a ''one-size-fits-all'' plan, would only save seniors, on average, 12 percent off retail prices. Our seniors will be able to get the best possible price on their medicines.

In addition, our plan requires companies to offer multiple drugs in each category—not just one as the Democrat's bill does. And our bill requires coverage of off-label uses of drugs, while the Democrat's bill does not. That's particularly important to the 60% of seniors who rely on off-label uses to threat their cancer.

And finally, with drug costs expected to rise 10 percent a year for the next decade, we think it's critical to adjust funding each year for drug cost inflation. In sum, the bipartisan bill creates a structure that will give seniors the best bang for their buck!

And for those who have great employer-provided retiree coverage, the House plan helps ensure that employers will continue to offer it. The bill provides employers with subsidies to address the cost of offering seniors insurance against catastrophic drug costs. The Democrat plan does not provide this same public-private partnership to preserve private retiree health coverage. Our legislation will not jeopardize the coverage that seniors already have, and they'll have the choice to keep it!

In addition to providing seniors with many choices, our legislation also contains an important initiative that I authored. For the first time, we will help seniors with serious chronic diseases—diabetes and heart disease. They will be able to enroll in a disease management program and will receive their prescription drugs at a low cost. By helping seniors manage their disease, we will be able to help them avoid hospitalizations and emergency room visits, thereby lowering Medicare spending. The private sector has moved ahead of Medicare and had success offering these programs. Now we'll be able to ensure that seniors on Medicare will have this choice to improve their health and lower Medicare's costs.

And finally, this legislation also includes an important provision for states like Connecticut that have already had the foresight to provide prescription drugs for low-income seniors. It assumes that these states will not be penalized, but rather helped to integrate their successful programs with this new federal benefit.

Indeed, this is a red letter day for seniors. The House is demonstrating its support on both sides of the aisle to commit significant funding to make prescription drugs available for the millions of seniors who are having difficulty meeting their health needs today. The AARP confirms this in a letter to Congress saying that we are taking ''important steps'' and that our work represents ''real progress.''

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. LEVIN), a member of the Committee on Ways and Means, who understands that the Older Women's League and the Alliance for Children and Families have endorsed the Democrat bill and violently oppose the Republican bill.

Mr. LEVIN. Mr. Speaker, the Republicans took the advice of their consultants. Look at the label, they said, and forget about the contents. It is true. They have used bottles and vials here on the floor; but for many seniors, they would be empty. If seniors have $1,000 in prescription costs, they would pay more for the insurance under the Republican plan than they would get back, and if it is $7,000 in medicine costs, seniors would pay 85 percent.

I ask this question: Why should coverage for medicines be different than for visits to physicians and to hospitals? We Democrats say there should be no difference. My Republican colleagues say, set it up under the private insurance plan. They say, ours is one-size-fits-all. Yes, ours is under Medicare that has choice. My Republican colleagues essentially do not build theirs within Medicare. They say have it through private insurance with no assured premium, and I emphasize this, and no assured set of benefits. We can do better.

Mr. THOMAS. Mr. Speaker, I yield as much time as he may consume to the distinguished gentleman from Illinois (Mr. HASTERT), the Speaker of the House.

Mr. HASTERT. Mr. Speaker, I thank the gentleman from California for yielding me this time.

Mr. Speaker, I rise today in support of this legislation, and I urge my colleagues on both sides of the aisle to support it.

There is one issue that should transcend politics, and this is it. Some analysts out there are saying that this is the big political vote of the year, and they may be right. But we should not vote for this out of a concern for political futures. We should vote for this out of the concern for our constituents who need our help in dealing with the high cost of prescription drugs.

We should do this to help our mothers and our grandmothers and our neighbors down the street. We should do this to help those seniors that gather for coffee every morning down at the local McDonald's. We should do this to help those who rely on prescription drugs to stay alive and those who need them to enhance their already vibrant lives. We should work together to provide our senior citizens a better quality of life.

No senior should be forced to choose between paying the rent and putting food on the table or paying for life-saving and life-enhancing prescription drugs.

Prescription drugs are too expensive in this country, and too many of our seniors do not have an adequate prescription drug benefit. This legislation addresses both problems in a responsible way that allows seniors to have a choice and not a one-size-fits-all Federal program. Those seniors who choose the plans offered by this legislation will reduce their prescription costs by 25 percent from the first day they enter the plan. By lowering the cost of prescription drugs, this proposal gives seniors the peace of mind that they are getting the best deal for their health care dollar.

The seniors I talk do not want a handout. They are willing to pay their fair share. But they do not want to be afraid of having all of their savings wiped out if they find that they have an illness that has a very expensive drug treatment.

Mr. Speaker, our plan insures seniors against such catastrophic loss from the day this plan becomes law, not 6 years from now, as the Democratic plan does. Seniors need coverage now. We all have a special concern for low-income seniors. They will be fully subsidized by the Federal Government. All seniors will have insurance against high out-of-pocket costs.

Mr. Speaker, there is much talk from some members of the minority about our motivations for bringing this bill forward. They say we are doing the bidding of the insurance company. Well, I will say to my colleagues, last week they criticized the plan because the insurance company did not like it. They say that we are in the pocket of the pharmaceutical industry when, in fact, our bipartisan bill would cut drug costs by 25 percent and theirs only by 12 percent. They turn to the usual excuses that this bill does not do this or it does not quite do that; Republicans do not like Medicare; or Republicans do not like seniors.

It seems to me that some Members may be looking too hard for an excuse

to vote against this bill. Democracy sometimes looks a bit chaotic. Those who are watching this debate can attest to that. But I am disheartened by a story that I saw on the wire last night.

According to the Associated Press: ''Democrats have already begun testing campaign commercials, preparing to hit Republicans for failing to offer prescription drug coverage to seniors.''

My friends, put those commercials away. America is sick and tired of bickering. Americans want us to create a product that will benefit them.

□ 1515

Join us in a bipartisan effort to give senior citizens a Medicare-based prescription drug benefit. The time for demagoguery is over. It is time to modernize Medicare by adding a prescription drug benefit so that all seniors can get the chance to enjoy their golden years.

Mr. STARK. Mr. Speaker, I yield myself 10 seconds.

Mr. Speaker, I would inform the House that the minority office of the Committee on Ways and Means just received a telephone call from the executive director of the National Alliance for the Mentally Ill, which one of the previous speakers on the Republican side said endorsed the Republican bill. They said they do not, that that was a misstatement.

Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts (Mr. NEAL), who understands that the Network of National Catholic Social Justice Lobby does endorse the Democrat bill and oppose the Republican bill.

Mr. NEAL of Massachusetts. Mr. Speaker, let me just call attention to something, with great deference, that the Speaker said. He says this should be above politics. Is he not right?

Try to square that with the argument in front of us that we were not even allowed as members of the Democratic Party to bring an alternative to the floor. Do Members know why we could not bring an alternative to the floor? Because we would have won. We would have peeled off enough Members from the Republican side who would have voted for our plan, because this battle is about certainty versus uncertainty.

Is there anybody who believes that the Republican party would do a better job with Medicare than we would? We argue that a certain benefit kicks in on a certain date and people can rely upon it. They argue that we should subsidize the insurance industry to provide a benefit to the general citizenry.

Let me quote Chip Kahn, a former Republican staff director of the Subcommittee on Health: ''We continue to believe that the concept of the so-called drug-only private insurance simply will not work in practice. Designing a theoretical drug coverage model through legislative language does not guarantee that the private insurers will develop that product in the market,'' end of the argument.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Texas (Mr. SAM JOHNSON), a member of the Committee on Ways and Means, a member of the Subcommittee on Health, and a Medicare beneficiary.

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, this prescription drug plan gives American seniors choices. They can choose a new plan or they can keep the plan they already have. This is in stark contrast, no pun intended, to the Democrat plan that forces seniors into a government-run bureaucracy-led program that will leave seniors without the choices they deserve.

Do Members remember when we were kids and we used to talk to each other with this antiquated communication system, talking through the cup and listening on the other end? Today's Medicare program is like two Dixie cups connected by a string. We can talk to one another, it works, but it does not meet the communications demands of the 21st century.

Medicare today sometimes works, but our seniors deserve a program that meets their health needs in the 21st century. That includes prescription drugs. This bill will bring Medicare into the 21st century.

Mr. STARK. Mr. Speaker, I am pleased to yield 1 minute to the distinguished gentleman from Tennessee (Mr. TANNER), a member of the Committee on Ways and Means, who knows that the Consortium for Citizens With Disabilities and the National Academy for Elder Law Attorneys both support the Democratic bill and oppose the Republican bill.

(Mr. TANNER asked and was given permission to revise and extend his remarks.)

Mr. TANNER. Mr. Speaker, I am in favor of Medicare revision and all of the things that the previous speaker said. The problem with the Republican bill is they are trying make an insurance product out of a benefit, and one cannot do that. Insurance is a pooling of risk. When all of the claimants are beneficiaries, there is no pooling or spreading of risk. Therefore, it has to be a benefit.

Put another way, if everyone's house burned down, we would not be able to purchase fire insurance in the private marketplace, simply because they would not be able to offer it.

This is particularly true in the rural areas. Short of importing people into the rural areas, we do not have HMOs. We do not have satellite dishes because we think it is cool, we have satellite dishes because there is no cable TV in rural areas. There are no HMOs in the rural areas.

Therefore, we have to have a defined benefit under Medicare if we truly believe in delivering a prescription drug benefit to the senior citizens, all of them, in this country.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Kentucky (Mr. FLETCHER), a medical doctor and someone who has provided considerable assistance in writing a plan that not only works but also meets the needs of seniors.

Mr. FLETCHER. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I am very disappointed in the minority. They seem to want to obstruct this very important legislation and benefit for our seniors for political purposes. That is very disturbing.

Let me tell the Members, this bipartisan bill we have will benefit 606,000 Kentuckians, people like Lois Hamilton from Stamping Ground, Kentucky, who makes $700 a month and has several hundred dollars of prescription drug costs. This will pay for her medication so she does not have to make a choice between food on the table and providing the medicine she needs to make sure she continues her health.

Let me tell the Members about the partisan plan, I will call it. It sets up a plan where there is a single government-mandated plan.

Let me talk about the Canadian plan for a minute. There, they cannot get the latest, even though it is approved by the FDA, they cannot get the latest medications for breast cancer, for metastatic ovarian cancer, metastatic colon cancer. That is because they have run a system under a mandated single plan. That is what the minority wants. Our plan offers a choice of plans, a voluntary plan that is affordable for everyone. I encourage my colleagues to support it.

Mr. STARK. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Maryland (Mr. CARDIN), who knows that the National Association of Area Agencies and the Center for Medicare Advocacy, Incorporated, of the Health Care Rights Project both endorse the Democratic bill and oppose the Republican bill.

(Mr. CARDIN asked and was given permission to revise and extend his remarks.)

Mr. CARDIN. Mr. Speaker, the Sun Papers, my local paper, in looking at a plan that solely relies upon private insurance, said in this morning's editorial, ''Some Congressional Republicans concede it is an unworkable approach. Even health insurance companies oppose this plan. They know there is little or no profit in it for them, but plenty of administrative headaches. The best way to handle a prescription drug program is through the existing Medicare system.''

Mr. Speaker, that is a system that works on a 3 percent overhead versus private insurance at 25 percent overhead, one that guarantees benefits to our seniors, unlike the Republican bill, that does not guarantee any specific benefit or any specific premium to our seniors.

Mr. Speaker, the Sun Papers goes on to say, ''The Republican plan should be rejected. A more sensible approach championed by the Democrats would be tying prescription drug subsidies to the existing Medicare program.''

The Sun Papers called the Republican plan ''a placebo, which the dictionary defines as a substance containing no medication and given merely to humor a patient.'' This is an apt description of the Republican plan. It should be rejected.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Arizona (Mr. HAYWORTH), a member of the committee who has more than three-quarters of a million Medicare beneficiaries in the State of Arizona.

Mr. HAYWORTH. Mr. Speaker, I thank the chairman of the Subcommittee on Health for yielding time to me.

I would echo the words of our speaker, that no senior should be forced to choose between putting food on the table or paying for the prescription medications they need. That is just plain wrong.

But by the same token, the question we need to ask today, and why I rise in support of our bipartisan plan, is that we need to fairly ask, who is in charge? Mr. Speaker, I come to the floor today to reassert the authority of seniors to choose the type of benefit they want. That is the major difference.

Our friends on the left, advocates of big government, say, let the Washington bureaucrats do it. Let us put the bureaucrats in charge of the pharmacies. Let us put the bureaucrats in charge of the plans. We say no, let us ensure freedom of choice. Give seniors choices and let them decide what is best.

Mr. Speaker, simply stated, the plan on the left would fill the medicine bottles of America with red tape. We do not need that. Our seniors need choice. Support the bipartisan plan.

Mr. STARK. Mr. Speaker, I am privileged to yield 1 minute to the gentleman from California (Mr. BECERRA), the next mayor of Los Angeles and a distinguished member of the Committee on Ways and Means, who knows that the American Federation of Teachers and the National Hispanic Council on Aging have both endorsed the Democratic bill and opposed the Republican bill.

Mr. BECERRA. Mr. Speaker, I truly thank the gentleman for yielding the 1 minute to me.

Mr. Speaker, what American seniors want is a real plan, a plan that is defined, a plan that is dependable and guaranteed with regard to the benefit for prescription drugs, and a plan that fits within Medicare.

Does H.R. 4680 provide any of those things? No, it does not. H.R. 4680 puts $40 billion in the hands of the insurance industry and HMOs and says, you now go out and offer in the private sector an insurance policy that right now they are not willing to do, because they do not like to offer insurance plans for prescription drugs to seniors because it costs too much.

So by giving them $40 billion, we are giving them a bone saying, okay, you get $40 billion to offset some of those costs. Come on, this is your incentive. Go offer plans in the private sector for folks to buy.

This puts nothing in the hands of seniors except a charade. It is giving them a coupon and saying, go out and see if you can find something now for that coupon. Medicare guarantees a right to a doctor, it guarantees a right to a hospital. It should guarantee a right to prescription drugs. Vote against this bill.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Minnesota (Mr. RAMSTAD), a member of the Subcommittee on Health of the Committee on Ways and Means.

Mr. RAMSTAD. Mr. Speaker, I thank the chairman for yielding me the time.

Mr. Speaker, I rise in strong support of the bipartisan prescription drug plan. It is bipartisan. I want to pay special tribute to my friend and colleague, the gentleman from Minnesota (Mr. PETERSON), a member of the other side of the aisle, a Democrat who worked hand-in-hand with all of us on the Prescription Drug Task Force to craft this truly bipartisan, pragmatic plan. I thank the gentleman for putting the interests of Minnesota seniors ahead of politics.

We should all put the interests of America's seniors ahead of politics and pass this bipartisan plan today. It truly is, Mr. Speaker, all about choices. The question we must ask ourselves, if health care choices are okay for Members of Congress, why are some so opposed to expanding choices for our seniors?

Let us not try to have it both ways. Let us expand choices for seniors. Seniors deserve choices in their health care just like younger Americans, just like Members of Congress. This bill, this bipartisan bill, guarantees all seniors access to at least two different health plans.

Do not take choices away from seniors. Let us give them the choices, the access, to prescription drugs that they deserve.

Mr. STARK. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Maine (Mr. ALLEN), a gentleman who understands that the American Federation of State, County, and Municipal Employees and AFSCME retirees both endorse the Democrat plan and oppose the Republican plan.

Mr. ALLEN. Mr. Speaker, this is a day of shame for the House of Representatives. The Republican leadership will not allow a vote in a debate on the Democratic prescription drug benefit under Medicare. Instead, Republicans have produced a bill that says to our seniors, HMOs and insurance companies can help you. We will give those companies your tax dollars, and we will hope they will offer you insurance coverage.

But the insurance companies are saying loudly and clearly, we will not provide stand-alone prescription drug coverage. Every day in this country seniors do not fill their prescriptions. They cut their tablets in half. They do not take their medicines or do not eat well because the most profitable industry in this country is charging the highest prices in the world to people who can least afford it, including our seniors.

Canadians, Mexicans, HMOs, insurance companies, they all pay far less than our seniors. The Republican bill is not relief for seniors, it is a prescription to protect drug company profits and Republican Members of this House from defeat in November.

Mr. Speaker, when we look at a person who pays $2,300, they will wind up paying $1,700 out of their own pocket under the Republican plan. That plan is a fraud.

□ 1530

Mr. THOMAS. Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield 1 minute to the distinguished gentleman from North Dakota (Mr. POMEROY), the former insurance commissioner of North Dakota.

Mr. POMEROY. Mr. Speaker, I hope today's debate represents bipartisan consensus that we need to help our seniors with the high cost of prescription drugs. The choice, however, presented on the House floor falls far short of meeting that need, because we will only be allowed to vote on the proposition that we should take Federal dollars, send it to insurance companies and hope that they provide benefits to seniors.

Mr. Speaker, I used to be an insurance commissioner. I regulated insurance companies. The dollars that the majority would propose for insurance companies will go to sales commission, it will go to insurance company executive salaries, it will go to fancy office buildings. It will not go to the hard coverage that our seniors need for the high cost of prescription drugs.

It is not the way to go. The way to go is the alternative that we will not be allowed to vote on, Medicare coverage for prescription drugs. It is time to update the coverage of the Medicare program and offer the protection our seniors need. North Dakota's seniors want Medicare coverage for prescription drugs, not an insurance company sham.

Mr. THOMAS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. STARK. Mr. Speaker, I would like to inquire of the gentleman from California (Mr. THOMAS) how many speakers he has remaining.

Mr. THOMAS. Mr. Speaker, it is indeterminate at this time.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Texas

(Mr. DOGGETT), a member of the Committee on Ways and Means who understands that the American Association of Mental Retardation and Elder Care America both endorse the Democratic bill and oppose the Republican bill.

Mr. DOGGETT. Mr. Speaker, I thank the gentleman from California for yielding me this time.

Mr. Speaker, we consider this bill today for one reason and one reason only: the Republicans took a poll. Here are the results in this report. Their pollster told them that Americans believe, ''Republicans aren't doing anything for seniors.''

I cannot believe these folks paid good money to learn the obvious. For the last 6 years, a principal Republican concern for seniors has been how to dismantle Medicare, or in the words of their great leader, how to let Medicare ''wither on the vine.''

Then this pollster gave them four pages of what were called ''phrases that work'' to explain away the well-justified feeling of the American people that Republicans are totally indifferent to the plight of seniors who have to choose between purchasing groceries and prescription medications.

And here are particularly important words from Public Opinion Strategies delivered to the Republican Caucus: ''It is more important to communicate that you have a plan than it is to communicate what is in the plan.''

This is not a plan. It is a ploy. The Republican Congress is a prescription for failure.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD). The Chair would ask all Members to abide by the time that they are allotted.

Mr. THOMAS. Mr. Speaker, it is now my pleasure to yield 1 minute to the gentleman from Florida (Mr. FOLEY), a member of the Committee on Ways and Means.

Mr. FOLEY. Mr. Speaker, maybe people should switch to decaf around here. A little excited. A little tense. I know they want to leave the Capitol, but they should remain and discuss the issue.

It is so complicated, our Medicare prescription drug coverage. It is so hard to understand. And yet every Member of Congress is entitled to it. I do not hear any of them turning in their cards because it is difficult to get prescription drug coverage.

They can go to the pharmacy. They can order from Merck-Medco. They can go to any place in America and get covered under their policy here, provided by the taxpayers, at the House of Representatives.

But today, Mr. Speaker, a similar plan is being offered for our seniors and is this abomination? Now, we can have disagreements on policy; we can certainly have disagreement on how we arrive. But I would suggest this is a good plan. And if we wait 48 hours, AL GORE will endorse it; and the President will support it. He did not like marriage penalty elimination. It was too expensive. Give him a month; he will support it and trade us drugs.

Mr. Speaker, I urge my colleagues to vote for a very good, responsible policy and give the seniors drugs they need.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. JEFFERSON), a distinguished member of the Committee on Ways and Means who understands that the Friends Committee on National Legislation and the International Union of United Automobile, Aerospace, Agriculture and Implement Workers both support the Democrat bill and oppose the Republican bill.

Mr. JEFFERSON. Mr. Speaker, I thank the gentleman from California (Mr. STARK) for yielding me this time.

Mr. Speaker, I am glad my colleagues on the other side of the aisle have finally turned to a discussion of our Nation's most pressing priority, the need to ensure affordable access for seniors to prescription drugs. Unfortunately, Mr. Speaker, the debate is all that we really have.

The sharp rise in prescription drug prices has placed an intolerable burden on our Nation's seniors. This burden is aggravated by the fact that there is no Medicare prescription drug benefit. Three-fourths of Medicare beneficiaries lack decent, dependable coverage of prescription drugs.

Our Nation's seniors are not fooled by this legislation that is on the floor today, Mr. Speaker, and neither are we. A clear majority of senior and consumer groups have labeled this legislation a ''sham,'' providing no real hope of a solution.

We need a bill that will afford a solid guarantee of a drug benefit for all Medicare beneficiaries, not a bill that relies on the profit-driven whims of the private insurance industry. If Medicare is indeed an entitlement program for seniors, should we not pass a drug benefit bill that clearly lets seniors know what drug benefit they are going to get and they are entitled to?

Mr. Speaker, the program we have in front of us makes no sense. I hoped for a real choice today. It is a shame we do not have it. Our Nation's seniors deserve better.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentlewoman from Connecticut (Mrs. JOHNSON), and I hope this is not disruptive of the debate, who wishes to talk about something that is actually in the bipartisan plan.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from California for yielding me this time.

Mr. Speaker, in my earlier remarks, I did mention the breadth of formulary that seniors would have access to under the Republican bill, because they would have access to competing plans. So they would have access to a number of prescription drugs in every category, and assurance that off-label use of drugs, so important to cancer treatment, will be at their beck and call.

But there is another wonderful provision of the bill that I want to point out to my colleagues. It allows our seniors to participate in a demonstration project if they are diagnosed with advanced stage congestive heart failure, diabetes, or coronary heart disease.

These are the very seniors with the highest drug costs, and participating in these disease management programs will enable them to get their pharmaceuticals essentially covered and through a disease management approach they will get support in recovering and adopting preventative health life style changes, following all of their doctor's orders, that will improve their health and reduce their health care costs all the while covering their drug costs. It has been proven that disease management lowers hospital costs, lowers doctor costs, lowers emergency costs. Good for Medicare and good health for seniors.

Mr. STARK. Mr. Speaker, I yield such time as he may consume to the gentleman from Pennsylvania (Mr. MASCARA).

(Mr. MASCARA asked and was given permission to revise and extend his remarks.)

Mr. MASCARA. Mr. Speaker, I rise in opposition to H.R. 4680.

Mr. Speaker, I come to the floor today to air my deep concerns regarding the lack of prescription drug coverage for many of our nation's seniors.

Last year I introduced H. Con. Res. 152, which called upon Congress to fix this problem. The bill we are debating today does nothing to fix the problem.

I am sure my colleagues here in the House are aware of enormity of this issue. They know that upwards of 14 million seniors in this nation are without any kind of prescription drug benefit. They know that millions of seniors are suffering in ways that are morally wrong, especially for such a wealthy and caring nation.

How can we on one hand give away billions of dollars in foreign aid, yet turn our backs on seniors who often times must choose between buying food or buying prescription drugs.

This bill can't see the forest for the trees. It does nothing to solve the problem on how to provide 13 million seniors with adequate prescription drugs at an affordable price.

This bill H.R. 4680 does not accomplish that. I oppose it and ask my colleagues to vote ''No.''

Mr. STARK. Mr. Speaker, I yield such time as he may consume to the gentleman from Indiana (Mr. VISCLOSKY).

(Mr. VISCLOSKY asked and was given permission to revise and extend his remarks.)

Mr. VISCLOSKY. Mr. Speaker, I rise in opposition to H.R. 4680.

Mr. Speaker, I rise today to express my strong opposition to H.R. 4680, the Medicare Rx 2000 Act. This overly complicated bill fails to guarantee affordable prescription drug coverage for all seniors and disabled persons. Prescription drug coverage for seniors is one of the most serious issues facing this Congress, and it is time to stop making empty promises.

I am a strong supporter of responsible Medicare prescription drug coverage for our senior citizens. Coverage that ensures that seniors do not have to make life and death monetary choices, coverage that at the same time does not bust the budget and represents a promise we can keep. I therefore believe that any program we pass must have a co-pay, premium, and benefit cap. It is important that we pass meaningful and real prescription drug coverage. To do less is a cruel hoax to the elderly of this country.

When Medicare was created in 1965, prescription drugs did not play a significant role in the nation's healthcare. Today, prescription drugs have become an increasingly important part of seniors' health care. The drugs that are now routinely prescribed for seniors to regulate blood pressure, lower cholesterol, and ward off osteoporosis had not even been invented when Medicare was created in 1965. Instead of frequent doctor visits and expensive hospital stays, today's innovative drugs keep more seniors out of the doctor's office and away from hospitals.

Unfortunately, drug prices have been rising rapidly. National spending on prescription drugs increased 51 percent between 1990 and 1995. More than one-third of seniors on Medicare spend over $1,000 a year on their drug prescriptions. There are approximately 13 million seniors with no prescription drug coverage, and another 13 million have coverage which is inadequate, costly, or both. As this trend continues, drug expenses threaten to erode many seniors' modest incomes even further, placing more and more Americans in a difficult position reminiscent of an earlier era.

A constituent of mine, Eunice Bailey, a 69-year-old resident of Hammond, Indiana, receives a monthly Social Security check of $840. Unfortunately, Ms. Bailey is not only a diabetic, but suffers additionally from high blood pressure, high cholesterol, arthritis, and osteoporosis. In an average month, Ms. Bailey can spend close to $300 for her prescription drugs, not to mention $225 in rent, $280 in groceries, and $120 for her utilities and telephone. This leaves Ms. Bailey with a deficit of $85. Since she cannot possibly afford to buy medicine and pay for her basic living expenses, Ms. Bailey saves money by either splitting her pills in half, or simply does not purchase her medicine at all. In addition, Ms. Bailey sometimes finds herself reducing the amount of food she purchases, a dangerous thing to do considering she is a diabetic. I find this absolutely appalling. In a country as wealthy and as good as the U.S., no citizen should have to decide between buying food or buying medicine.

Unfortunately, the Republican bill provides subsidies to private insurance companies while denying a real prescription drug benefit for all. The plan would only provide financial incentives to encourage private health insurance companies to offer ''Medigap'' policies to provide prescription drug coverage. This approach simply will not work. It will force seniors to deal with private insurance companies rather than having the choice of getting their prescriptions through Medicare. The Health Insurance Association of America has even stated that many private insurance companies still will not offer Medigap drug policies because they will not want to assume the financial risks. The end result is that millions of individuals will not be guaranteed access to prescription drug coverage at an affordable price.

Additonally, it will do nothing to control the cost of drugs since it would not provide for direct negotiations with prescription drug companies. Instead, it creates small purchasing groups that will have little leverage in getting better prices for seniors. We need to be providing seniors the same benefits that other large purchasing groups, like HMOs, currently get.

The only way to guarantee an affordable prescription drug coverage for all elderly and disabled persons is to expand the Medicare program to include prescription drug coverage. Like the existing hospital and medical coverage under Medicare, a new prescription drug program should benefit everyone, not just the insurance companies. There is no reason why we cannot be fiscally responsible while balancing people's health care needs. Providing a prescription drug benefit for our seniors will result in savings to both consumers and American taxpayers by reducing expensive hospital stays and medical bills.

As you cast your vote this week, remember that the Republican plan is a huge misstep toward providing real Medicare prescription drug coverage for our seniors. A stand-alone, drug-only policy will not work. It provides false hope to people who need help, and will do more harm than good. It is time to move past the empty rhetoric and join together in the fight to provide substantive assistance to America's senior citizens like Eunice Bailey.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentlewoman from New York (Mrs. MCCARTHY).

Mrs. MCCARTHY of New York. Mr. Speaker, I would like to speak as a nurse. I can tell my colleagues, in the last few months these are the bills that my senior citizens have sent to me. And I am telling my colleagues that the plan that is being put on the floor today will not help my senior citizens and that is a shame.

I am here to fight for my seniors so they can take their medications. I think what everyone is forgetting, the majority of people that cannot buy their medications cannot also afford the premiums. When we see the insurance companies saying this plan cannot work, then I as a nurse have to stand up and say let us do something right. Let us take care of our seniors, and let us stop playing politics with this.

This will help so many of my seniors if we could do something for them. Let us think about how much money we are going to end up saving if our seniors take their medications, so they do not end up calling for an ambulance, ending up in the emergency room causing our health care costs to go up even more than they are.

Mr. THOMAS. Mr. Speaker, it is now my pleasure to yield 1 minute to the gentleman from Florida (Mr. SHAW), who has more than 2.7 million Medicare beneficiaries in his State.

Mr. SHAW. Mr. Speaker, I thank the gentleman from California for yielding me this time.

Mr. Speaker, I want to compliment the gentleman and the colleagues that originally cosponsored this bipartisan plan on both sides of the aisle.

Mr. Speaker, there can be criticism for this plan. There is no question about that. No plan is perfect. But let us look closely at what this plan offers. It offers choice. Our seniors want choice. That is an important thing.

It offers catastrophic care on drugs, and that is tremendously important. The expense of drugs is becoming more and more expensive as they become more and more sophisticated and more and more part of our health care plan.

This is a tremendously important step. Can we do more? Yes. But should we get into a bidding war? Should we turn this into an auction? No. We need to put this plan into place. It is a good plan. We can say it is a good first step; we can do more. This is the plan that we are working with, and this is the plan that I am very hopeful that we will retain our bipartisan support for.

Mr. Speaker, I rise in support of H.R. 4680, the Medicare Prescription 2000, which is a historic first step towards modernizing the Medicare health benefits that nearly 40 million senior citizens and disabled citizens of all ages rely on for all their health care needs.

Mr. Speaker, I have the honor of representing a congressional district that is home to the largest number of senior citizens and Medicare beneficiaries in America. So perhaps more than other member of this House, I am concerned about doing what is best for preserving and improving the Medicare program which has served seniors and the disabled so well for the past thirty-five years.

Is the current Medicare program perfect? Does the current Medicare program cover every service and meet every medical problem that seniors and the disabled have? We all know that it doesn't. No one knows better than I do, as Chairman of the House Social Security Subcommittee, that both the Social Security and Medicare programs need to be updated in order to be prepared for the large wave of baby boomers who will begin retiring soon. This Congress, and the last Congress and the next Congress have been grappling with the many competing ideas for modernizing Social Security and Medicare. There clearly is no consensus on what the silver bullet is for Social Security or for Medicare. What is clear is that I am committed to work with Chairman ARCHER and Chairman THOMAS and all my colleagues on the Ways and Means Committee and, indeed, all the members of this House to improve these two programs that provide security for the seniors I represent. What I would say to my colleagues who claim that H.R. 4680 isn't adequate, is that it is a very good first step. Let me be clear, however, this is just not just a symbolic first step—this bill will provide real prescription drug coverage for any senior who chooses it.

As a matter of fact, choice is one of the most important features of Medicare Prescription 2000. H.R. 4680 preserve's senior's choice on many different levels. First, I respect my seniors wishes to choose the coverage that is best for their individuals health care needs. I also respect individuals wishes to choose to not participate in one of these new Medicare prescription drug programs. Second, many of my seniors—over 150 of them—have taken the time to write and call me over the last month in order to let me know how happy they are with the prescription drug coverage

and other benefits they are receiving through their Medicare+Choice HMOs. Mr. Speaker, this bill will respect their wishes to choose to remain in their Medicare+Choice plans. Third, this bill also protects the many retirees who have excellent retiree prescription drug coverage through their former employer. Finally, and most importantly, this bill gives seniors who want to participate the choice between at least two different prescription drug plans no matter where they live. Whether a senior lives in a large metropolitan area like the greater Miami-Ft Lauderdale-Palm Beach area or in the rural areas of Central Florida or in the Mid-West, every senior will be able to choose a plan that is best for them—not a plan that a government bureaucrat imposes on them and every other senior citizen in America. I, for one, do not believe, like the President's does, that the Health Care Financing Administration should make this choice for seniors. Under his plan, the President wouldn't give seniors any such choice. It would force seniors to choose between a government-run plan or nothing.

Another important provision of this bill is peace of mind for every senior citizen who fears that they and their loved ones could be faced with large drug bills reaching into the hundreds of thousand of dollars. The Medicare Prescription 2000 bill protects all seniors from catastrophic drug expenses—once a senior's drug costs exceed $6000 in a year, this plan will completely cover the rest of their drugs for the year. Unfortunately, the President's plan did not protect beneficiaries from these huge expenses until our Republican plan came out—now the President has agreed that this was a major oversight in his plan and has agreed to support it.

Mr. Speaker, this plan also has special provisions to make sure that low-income seniors will have all their drug expenses covered by Medicare. And this plan helps make prescription drugs more affordable for all seniors by ensuring that they get the same drug-price discounts that each of us enjoys when we buy drugs through our private health insurance plans. The Congressional Budget Office has calculated that my seniors will save at least 25 percent on every prescription they buy under our plan. Other experts estimate that seniors could save between 30–35 percent on every drug purchase.

I would like to close by saying that the Medicare Prescription Drug 2000 bill will help the many seniors I represent who currently have no coverage. Am I satisfied that this is all Congress needs to do to improve the Medicare? No, I am not. But I am satisfied that this is a good place to start—just as Chairman ARCHER and I have done in announcing the outlines of our Social Security Reform proposal. By announcing the Archer-Shaw plan, we have started a rush of excellent Social Security reform ideas and suggestions from both parties. I believe that passage of H.R. 4680 will engender the continuation of a similarly energetic debate on how to build upon this newly created Medicare prescription drug benefit. I urge all my colleagues to vote yes on Medicare Prescription 2000.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. TURNER), who recognizes that the American Medical Student Association and the American Network of Community Options and Resources both support the Democratic bill and oppose the Republican bill.

Mr. TURNER. Mr. Speaker, the House leadership has twisted the rules today so that we have only one choice: their bill or no bill. So let us talk about what their bill does.

First of all, it gives millions of dollars to insurance companies instead of giving it back to seniors in the form of lower prescription drug prices.

Secondly, the bill leaves out middle-income Americans. Middle-income Americans cannot get any help. All they are told is to go buy insurance. There are millions of middle-income Americans who are struggling to pay the costs of high prescription medications.

Thirdly, this bill simply rewards the pharmaceutical industry who has spent almost $100 million trying to be sure that this bill that is on the floor today is the only bill we have a chance to debate.

A group called Citizens for Better Medicare, formed by the pharmaceutical industry, has worked hard to be sure that this day arrives in the form that we have it.

Finally, the Republican bill lets the greedy HMOs decide what medicines seniors get. We believe seniors and their doctors should decide what kind of medications they get.

Mr. THOMAS. Mr. Speaker, I yield myself 30 seconds. Mr. Speaker, I submit for the RECORD a letter from the National Alliance for the Mentally Ill. I initially said they supported H.R. 4680, which had been contradicted by the other side. And I believe the RECORD should show that the letter from the National Alliance for the Mentally Ill shows support for H.R. 4680. No number of denials will change the fact that they are in support.

Mr. Speaker, the letter reads as follows:

NATIONAL ALLIANCE
FOR THE MENTALLY ILL,
Arlington, VA, June 27, 2000.

Hon. J. DENNIS HASTERT,
Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: On behalf of the 210,000 members and 1,200 affiliates of the National Alliance for the Mentally Ill (NAMI), I am writing to thank you for bringing forward the Medicare Rx 2000 Act (HR 4680). This legislation offers tremendous potential for assisting Medicare beneficiaries with severe mental illnesses who do not currently have access to outpatient prescription coverage.

As the nation's largest organization representing people with severe mental illnesses and their families, NAMI has long argued for the need to modernize the Medicare program and include coverage for outpatient prescription drugs. The past decade has seen tremendous advances in treatment for severe mental illnesses such as schizophrenia, bipolar disorder and major depression. This is especially the case with respect to new medications such as atypical anti-psychotic drugs for schizophrenia and selective serotonin reuptake inhibitors (SSRIs) for bipolar disorder and major depression. Unfortunately, the lack of outpatient prescription coverage within the Medicare program has left beneficiaries without access to the coverage for the treatment they need.

NAMI is pleased that both Congress and the President have made legislation extending an outpatient drug benefit to Medicare a top priority in 2000. As part of NAMI's advocacy on this critically important issue, we have set forward a set of key objectives that we believe must be a part of any legislation Congress acts on this year. NAMI was pleased to offer these policy objectives in testimony to the Ways and Means Committee earlier this year. On each of these criteria, HR 4680 appears to meet the pressing needs of Medicare beneficiaries living with severe mental illnesses.

Eligibility for non-elderly disabled beneficiaries on the same terms and conditions as senior citizens—NAMI is pleased that HR 4680 does not restrict coverage to elderly Medicare beneficiaries and requires plans offering prescription coverage to do so on a non-discriminatory basis during specified open enrollment periods,

Affordable premiums, deductibles and cost sharing requirements—NAMI is pleased that HR 4680 specifies uniform, community-rated premiums for all beneficiaries and allows those below 135% of poverty to participate at no cost (with subsidized premiums for those between 135% and 150% of poverty), 135% and 150% of poverty),

Adequate coverage for catastrophic drug expenses—NAMI is extremely pleased that HR 4680 includes a ''stop loss'' provision that will protect beneficiaries whose out of pocket cost exceed $6,000 per year,

Bar on the use of overly restrictive formularies—NAMI is strongly supportive of provisions in HR 4680 designed to prevent use of overly restrictive formularies that limit access to the newest and most effective psychiatric medications. NAMI is also pleased that HR 4680 requires a process for beneficiaries to access coverage for medically necessary non-formulary medications in cases where a physician determines that a formulary medication is not as effective.

Mr. Speaker, as you know, 5 million Medicare beneficiaries are people with disabilities under age 65 (13% of the 39 million Americans on Medicare). It is important to note that 30% of these 5 million Medicare beneficiaries are non-elderly people with disabilities have incomes below 100% of the federal poverty level and that 63% are below 200% of poverty. Further, it is estimated that a quarter of these non-elderly disabled Medicare beneficiaries have a severe mental illness. NAMI feels strongly that this legislation is critically important to their ability to access adequate coverage for their treatment needs. While no single Medicare prescription drug proposal meets the unique needs of each and every beneficiary with a severe mental illness, it is clear that HR 4680 addresses many of the key concerns that NAMI believes must be a part of any legislation Congress acts on this year.

On behalf of NAMI's consumer and family membership, we would like to thank you for moving this legislation forward. NAMI looks forward to working with all House members—on both sides of the aisle—and the Clinton Administration to ensure that Medicare prescription drug legislation is enacted in 2000.

Sincerely,

LAURIE M. FLYNN,
Executive Director.

☐ 1545

Mr. STARK. Mr. Speaker, may I inquire of the time.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from California (Mr. STARK) has 1½ minutes remaining. The gentleman from California (Mr. THOMAS) has 4½ minutes remaining.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Iowa (Mr. NUSSLE), someone who has been extremely important in helping us shape the rural assistant portions of this particular legislation.

Mr. NUSSLE. Mr. Speaker, I thank the gentleman from California for yielding me this time.

Mr. Speaker, as the chairman of the Rural Health Care Coalition, one of the first things that I looked at in the draft of this particular prescription drug bill was whether or not it provided seniors choice, whether it provided them access, security and affordability.

First of all, on choice, the seniors that I represent in Iowa, they want to know that they are going to have choices in this particular bill. They are tired of a one-size-fits-all government program called Medicare that tells them exactly what to do, when to do it, how to do it, and takes the decision making away from doctors. This bill gives them a prescription drug plan to choose from.

Second it provides access. In rural Iowa, one has a real concern about whether or not the local pharmacy is going to be involved. This particular bill gives them access to their local pharmacies.

Finally, security and affordability, all rural seniors will be guaranteed a prescription drug benefit just like they are guaranteed drug benefits under all other Medicare benefits, and that once they reach $6,000, they will be held harmless.

This is the bill for rural Iowa, for rural America. Please support this bill.

Support H.R. 4680 for two important reasons.

I. PRESCRIPTION DRUG BENEFIT

H.R. 4680 provides rural seniors with choice:

All seniors will have at least two different prescription drug plans to choose from.

Rural seniors have to rely too much on Washington bureaucratic ''one-size fits all'' solutions to their health care.

This bill provides rural seniors with the ability to adapt drug coverage to meet their individuals needs, not to adopt coverage dictated by bureaucrats that don't fully understand the uniqueness of rural health care.

H.R. 4680 provides rural seniors with access:

All rural seniors will have access to their local pharmacies.

Pharmacists play a vital role in the delivery of health care to rural seniors. This relationship will not be compromised under this bill.

Medicare must require plans to provide access to ''bricks and mortar'' pharmacies.

Seniors who choose to receive their drugs through the mail will still be able to under this bill.

Medicare will work to ensure prescription drug plans provide seniors with the balanced benefits of being able to both consult with their local pharmacist face-to-face and receive their medications directly in their mailbox.

H.R. 4680 provides rural seniors with security and affordability:

All rural seniors are guaranteed a prescription drug benefit, just like they are guaranteed all other Medicare benefits.

All rural seniors will have the security of full catastrophic coverage once their drug bills reach $6,000.

Because of the market-based approach, all rural seniors will be provided with negotiated drug coverage savings.

II. MEDICARE+CHOICE

The BBA took steps to provide rural America with health care choices. However, these choices have been slow in reaching rural communities.

Because the delivery of health care in rural areas tends to be more efficient and wage rates in rural areas are typically lower, the Adjusted Average Per Capita Cost (AAPCC), the measure at which managed care plans are reimbursed under Medicare, for rural counties is less than other counties. As such, rural areas have difficulties in attracting health care competition.

In order to alleviate the discrepancy in AAPCC payments, the BBA: (1) established a national floor payment, and (2) changed the formula used to calculate the AAPCC to a blended rate of 50% local cost and 50% national average.

Unfortunately, annual Medicare updates have not provided enough funding to fully fund the blend.

H.R. 4680 addresses these problems by: (1) raising the national floor payment to $450; (2) eliminating the budget neutrality factor to fund the blend; and (3) allows plans below the national average to negotiate for a higher AAPCC.

H.R. 4680 takes a good step in the right direction towards stimulating health care competition in rural America.

Mr. STARK. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Tennessee (Mr. CLEMENT). The gentleman from Tennessee understands that the National Senior Service Corps Directors Association and the American College of Nurse Midwives both support the Democratic bill and oppose the Republican bill.

(Mr. CLEMENT asked and was given permission to revise and extend his remarks.)

Mr. CLEMENT. Mr. Speaker, I rise in opposition to the Republican prescription drug plan. First, there is no guarantee that these private insurance coverage companies will provide an affordable drug plan to seniors. Second, the Democratic plan that will not be considered today offers seniors a low, affordable premium. Third, the Republican plan would require seniors to shop around and find an HMO or insurance company to offer them coverage.

Mr. Speaker, under the Republican plan, the catastrophic coverage for seniors does not become effective until after $6,000 is spent while the Democratic plan is $4,000.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Michigan (Mr. CAMP), a member of the Subcommittee on Health of the Committee on Ways and Means.

(Mr. CAMP asked and was given permission to revise and extend his remarks.)

Mr. CAMP. Mr. Speaker, yesterday, I received a call from one of my constituents; and he told me that he currently receives prescription drug coverage from his employer. He wanted to ensure that prescription drug coverage was available for seniors that do not have any coverage at all, but he did not want to give up on the coverage that he already has.

The bipartisan legislation that we are discussing today protects him and everyone. It allows seniors with coverage to keep their plan. It allows seniors without coverage to choose from two plans. Not only can they elect to receive prescription drug coverage, they can elect not to receive it if they do not need it.

Our seniors spend more than any other age group on prescription drugs. This legislation brings the benefits of marketplace and negotiating power to our seniors. By negotiating with pharmacies and manufacturers, plans will seek the best possible discount. In fact, according to the nonpartisan Congressional Budget Office, our plan, the bipartisan plan, is expected to result in twice the reduction in drug costs as the alternative.

I ask Members to support the bipartisan drug plan.

Mr. STARK. Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois (Mr. DAVIS).

(Mr. DAVIS of Illinois asked and was given permission to revise and extend his remarks.)

Mr. DAVIS of Illinois. Mr. Speaker, I rise in opposition to the Republican proposal for a prescription drug benefit for seniors.

Mr. Speaker, I rise today in opposition to the Republicans' proposal for a prescription drug benefit for seniors. The House leaderships' decision to block a Democratic proposal shows their unwillingness to discuss a real drug benefit for seniors. This stonewalling is a sham of the legislative process.

As we know, the Medicare program provides significant health insurance coverage for more than 39 million seniors and disabled beneficiaries. However, the program fails to offer protection against the costs of most outpatient prescription drugs.

Prescription drug prices continue to rise and the percentage of Americans over age 65 is sharply on the rise. Medicare is therefore in need of modernization and the addition of a drug benefit for all beneficiaries, regardless of income level or location. The Republican plan falls far short of addressing the reality of the problem that many of our seniors face. I oppose the Republican proposal for three chief reasons:

First of all, their proposal is based on the faulty premise that insurance companies will write prescription drug plans for seniors. The insurance industry admits that this private insurance model will not work and leaders in the industry deny that such plans will even be offered. Charles N. Kahn, President of the Health Insurance Association of American—a group comprised of 294 insurance companies—told The New York Times on Feb. 21, 2000: ''I don't know of an insurance company that would offer a drug-only policy like that or even consider it.'' Mr. Kahn also comments that ''Private drug-insurance policies are

doomed from the start. The idea sounds good, but it cannot succeed in the real world.''

Even if insurance companies write drug plans for seniors, there will be instability in coverage. It is well known that health insurers would use the system to move in and out of markets depending on their advantage, not seniors' health. We see many examples of such pullouts today. This is not right. The Republican plan stresses competition in an already-flawed private Medigap insurance market rather than adding a prescription drug benefit to Medicare.

Secondly, the Republican proposal is not affordable: This plan offers no defined benefit. It appears to specify only the ''stop loss amount''—$2,100/yr, maximum limit on beneficiary out-of-pocket costs—while private insurers could define deductibles, co-pays, and benefit limits. Also, seniors would pay a $250 deductible. Furthermore, their plan would break up seniors into various private plans—if even written—and thus their bargaining power would be significantly reduced.

Finally, the Republican plan is not accessible to all Medicare beneficiaries: their plan fails to provide direct premium assistance for low- and middle-income Medicare beneficiaries. Any senior with an income above $12,600 will not have the assurance of lower premiums. This plan, therefore, does not protect against the risk of industry ''cherry picking'' and the negative selection of the sickest and disabled seniors. This is a Darwinian scheme where only the strongest survive.

Thus, I believe the Republican plan falls far short of providing a real drug benefit for our nation's seniors. The leaderships' denial to hear our alternative is a travesty.

I therefore rise in opposition to the Republican proposal.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume to bring this portion of the debate on our side to an end.

Mr. Speaker, we are denied, not only the last word, which I am sure the gentleman from California (Mr. THOMAS) will have, but we have been denied the opportunity to offer a bill.

Had we had the opportunity, we would of course have suggested that we spend more money, hundreds of billions of dollars more money to provide a seamless guaranteed dependable benefit to seniors who could have the unknowing security that the government would be there in the last resort if no insurance company showed up, to see that they got the pharmaceutical drugs at a reasonable price.

At a time in this country when we are so wealthy and when the surpluses are predicted to be many trillions of dollars, to me it is obscene to be sitting, offering to give away inheritance taxes and telephone taxes and taxes that nobody really cares about when we could be insuring our seniors, indeed we could be insuring our children and other folks in this country. But, no, this money is denied and is reserved for the wealthy few who would benefit from Republican tax cuts.

Oppose the Republican bill, please, and support whatever minor motion to recommit we are finally allowed.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 1 minute to the gentleman from Georgia (Mr. COLLINS), a member of the Committee on Ways and Means.

(Mr. COLLINS asked and was given permission to revise and extend his remarks.)

Mr. COLLINS. Mr. Speaker, I rise in support of this prescription drug bill for our seniors. It will be voluntary for our seniors. It will give them the freedom to choose as to whether or not to stay in a plan they may already be in or to choose this plan which they may need assistance for.

It will assist low income. It will also assist those who have high drug costs and catastrophic coverage. Others it will assist in a different way. It will help reduce the cost of drugs by having the administration deal with drug companies. It is very similar to the way we do with the Federal Employee Health Benefit Program, lowering the cost of those who have to pay the co-pay and those who would be between the low income and the catastrophic.

It is not a one-size-fits-all; that is for sure. I respect those who have the program or the plan that one size does fit all. But we must be aware of their plan, because of the back-end costs of their plans. We must be aware of the costs of any plan because, under the pay-as-you-go system, those who work today will pay the benefits.

It is not a perfect plan, but it is moving in progress, a work in progress.

Mr. THOMAS. Mr. Speaker, I yield myself the balance of the time.

Mr. Speaker, this really is an opportunity for the House of Representatives to address a problem that, frankly, needed to be addressed for some time. The two plans have a lot in common, but I do think people need to understand that the Democrats' plan does not afford seniors choice.

The bipartisan plan, not only affords them choice, but requires at least two options in every area of the country.

The way in which we have structured our plan, the Congressional Budget Office says we save seniors twice as much as the Democrats' plan out-of-pocket. We provide pocketbook protection now. It is not true of the Democrats' plan because they wrote a plan to fit a budget window. Not until 2006 does their catastrophic or out-of-pocket protection plan really begin.

AARP, the American Association of Retired Persons, has said the bipartisan plan is in Medicare, notwithstanding whatever may be said on the floor today. The American Association of Retired Persons has said this is an entitlement regardless of whatever may be said on the floor today.

Most importantly, it provides seniors comfort and assurance that the bipartisan plan is a prescription drug benefit in statute. No amount of an attempt to confuse seniors should alter that position. This is in Medicare. It is an entitlement, and the benefit is in statute. Do not take my word for it. Take the word of the American Association of Retired Persons. Vote yes on H.R. 4680.

The SPEAKER pro tempore. The gentleman from Virginia (Mr. BLILEY) and the gentleman from Michigan (Mr. DINGELL) each will control 30 minutes.

The Chair recognizes the gentleman from Virginia (Mr. BLILEY).

Mr. BLILEY. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, I am pleased to give my full support to the bill before the House today, H.R. 4680, the Medicare Prescription Drug Act of 2000. This bill would provide for a universal, voluntary, and affordable drug benefit to Medicare beneficiaries.

I have been studying this issue for some time. In addition to the five hearings our Subcommittee on Health and Environment held on this issue, I worked closely with a group of my colleagues on the Committee on Commerce for months studying different models for delivering drug coverage to seniors that offer them choice and affordability.

Through this effort, a number of things have become clear to me. First, seniors want security, and they want choice. H.R. 4680 ensures that every Medicare beneficiary will have access to at least two choices of drug coverage everywhere in America. This proposal also provides, for the first time in the Medicare program, protections for those beneficiaries who have the highest out-of-pocket spending on drugs. True security is knowing one will not have to mortgage one's home or become Medicaid dependent because of one's prescription drug needs.

Second, HCFA's house is not in order and cannot be asked to take on the task of administering a new drug benefit. One example of problems we have experienced with HCFA in the area of drug coverage is its policy on coverage for self-injectable drugs. Prior to August 1997, HCFA covered self-injectable drugs when administered by a physician. In August of that year, however, HCFA issued a program memorandum to its carriers instructing them not to pay for drugs that can usually be self-administered, regardless of the patient's health condition.

As a result of this instruction, many Medicare beneficiaries lost coverage for drugs that had been previously covered. These were MS victims and people in the late stages of cancer who could not possibly be expected to inject themselves with a needle. I find this totally unacceptable and am pleased that this bill includes language to permanently correct this problem.

H.R. 4680 creates the Medicare Benefits Administration which will administer the new drug program as well as the Medicare+Choice program. I am not convinced that HCFA can be reformed to better meet beneficiary needs. More fundamental change is needed, a shift in the culture of the agency from one that micromanages benefits and administers prices to one that is more flexible, that adapts to changes in the marketplace, and has

the expertise to negotiate with providers on behalf of Medicare beneficiaries. I believe the Medicare Benefits Administration is designed to meet beneficiaries' needs.

Third, many seniors have drug coverage today that they like and want to keep. A key feature of our plan is that it is voluntary, and it preserves the good coverage that many seniors have today. Our proposal encourages employers to continue providing coverage by giving them access to the new reinsurance pool for beneficiaries with extraordinary drug costs.

Mr. Speaker, Medicare needs to be modernized to reflect how health care is delivered today. By denying the seniors the types of choices we all have as Members of Congress, we are relegating them to a system of care that does not meet the high standards we want for ourselves, our staffs, and our families.

I have been in this institution for 20 years, and I have seen thousands of bills come up for votes, some small in scope, some large. Many of the laws we pass do not stand the test of time. Medicare is an exception to that rule. It has fundamentally shaped the way health care is delivered in this country and provides needed coverage for millions of seniors and disabled Americans. But the program is not keeping pace with the change we have seen in medicine. A pill or an injection has, in many instances, replaced the need for a surgeon to use his scalpel. This is amazing progress that should continue without our interference.

This bill is about more than drug coverage. It is about ensuring that the Medicare program continues to meet the needs of a growing number of elderly and disabled. It has my full support, and I urge all my colleagues to support it as well.

Mr. Speaker, I reserve the balance of my time.

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Mr. DINGELL. Mr. Speaker, I yield myself 2½ minutes.

Mr. Speaker, this ''bipartisan bill'' our Republican colleagues have put on the floor reminds me of a great story. A fellow went into a restaurant and asked for stew. He was delivered stew, and he said, ''Oh, that's the worst I ever had. Where did you get it? What's the recipe?'' They said, ''It's easy. It's horse and rabbit stew.'' He said, ''What is the recipe for it? It's the worst I've ever had.'' They said, ''It's equal: one parts horse, and one rabbit.''

Well, that is kind of what we have here: it is bipartisan. Three Democrats support this outrage, the rest of the Democrats oppose it. This is a Republican bill that our Republican colleagues have finally decided they would put on the floor after the pollsters told them that they are in serious trouble on their opposition to something that the people want and the people need and that is good for the country. That is what is at stake.

There is a very simple difference between the two bills. One is that the Democratic bill helps seniors to get insurance coverage. The Republican bill only offers to subsidize insurance companies, if they can find an insurance company that happens to want some more money.

Now, having said that, the Democratic bill also sees to it that senior citizens and Medicare recipients get their pharmaceuticals at affordable prices. The Republican bill gives money to insurance companies to maybe pay to pharmaceutical houses so that both can make more money, if they decide they want it. That is what is at stake here.

Now, man and boy, I have been in this place for a long time. I have never seen a worse process than we are confronted with today. The Speaker says how he would like this to be bipartisan. Well, so would we. But it is not. Apparently, however, our Republican colleagues want this to be a partisan process. But I am not surprised, because this has been going on this whole session, and it is not something that we have not seen before.

I would just make another little observation for the benefit of my Republican colleagues. I have watched my Republican colleagues, going back to 1935, when the Social Security bill was enacted. The Republicans opposed enactment of the Social Security Act, and they fought it for everything they were worth. My Republican colleagues also opposed Medicare. And by and large, with the exception of 68 courageous decent men, they opposed the Patient's Bill of Rights. They have also opposed universal coverage of people under health insurance, again something that is desperately needed.

So this is not new. What we are observing is the Republicans are again looking after their rich buddies and seeing to it that the people who need help are going to get nothing. And I will simply point out there are few who will draw any significant benefits under this piece of legislation. It is a sham, a fraud and an outrage; and it is almost as bad as the process under which we function today.

It is a sham, a fraud and an outrage; and it is almost as bad as the grossly unfair process under which we function today, a process which denies the people of the United States a vote on a meaningful bill which really meets the needs of our retirees, and which does not simply benefit insurance companies and pharmaceutical manufacturers.

Medicare is one of our most successful social programs in history. It insures more than 39 million disabled and senior Americans, and has drastically reduced poverty and improved the health of our elderly.

Over the years, Congress has enacted a number of additions to the program, including coverage for physicians' services and coverage of certain preventive benefits. Now the House is being denied an opportunity to debate seriously the most significant program change in recent time—the addition of a prescription drug benefit to the program.

The private insurance market was not willing to provide meaningful, dependable coverage for seniors and the disabled in 1965. That is why we created Medicare. Today, the private market is failing to provide seniors with adequate coverage for prescription drugs.

We all know the important role prescription drugs play in our lives, and they are particularly important for seniors or the disabled. Yet, three out of five Medicare beneficiaries lack dependable coverage. Those without coverage are forced to pay for medically necessary drugs quit of their own fixed incomes, and too many forgo medications that will keep them healthy, out of the hospital, and living longer, more productive lives.

What this Congress does with regard to a Medicare prescription drug benefit will have a profound impact on America's seniors and disabled. Unfortunately, the Republican leadership's prescription drug proposal would break the promise that Congress made to America's seniors and the disabled over three decades ago. Instead of providing an entitlement to a guaranteed, affordable, defined benefit, the Republican drug bill is a sham and a scam.

The Republican leadership's prescription drug proposal relies on private sector insurance companies to deliver a benefit. These are the same companies that failed to provide adequate health insurance to seniors thirty-five years ago, and the same companies that are saying now the Republican proposal just won't work.

For the first time in Medicare's history, seniors and the disabled would not be guaranteed access to a standard benefit. Instead, they would be limited to whatever private insurance plans decided to sell precription drug policies in their area. Private plans could vary their benefits, vary their cost-sharing, and vary their networks of pharmacies. There would be no guarantee that the particular drug plan a senior needed would be available to them, and there would be no guarantee that a drug plan that a senior picked one year would be available the next year.

Unfortunately, we will not be allowed to vote for a real benefit. The Democratic substitute would have provided a guaranteed, affordable prescription drug coverage for every single senior and disabled person in Medicare. Whether they live in Miami, Ohio or Miami, Florida, seniors would be guaranteed the same benefit at the same premium. The Democratic substitute would guarantee seniors and the disabled access to the medically necessary drugs their doctor prescribes, and it would guarantee that they could continue to get their medication from their local pharmacist. Finally, the Democratic substitute should provide sufficient subsidies so that the benefit would remain affordable to all. That is why the Republican leadership will not even allow the House to vote on our substitute.

Members of Congress don't have a choice before them today. We must reject a bill that would undermine all the principles that has made Medicare the most successful social program in history. And we will need to wait for another day, or another Congress, to vote for a package that provides a real Drug benefit in the Medicare program.

Mr. BLILEY. Mr. Speaker, I yield 1 minute to the gentlewoman from New Jersey (Mrs. ROUKEMA) for purposes of a colloquy.

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I thank the gentleman from Virginia for yielding me this time to have a colloquy with our colleague, the gentleman from California (Mr. THOMAS).

Mr. Speaker, as the gentleman from California knows, we have heard concerns from our States, several of them, like New Jersey, Pennsylvania, and Connecticut, regarding the potential negative interactions between State drug assistance programs and H.R. 4680, this bipartisan bill. Has the gentleman been made aware of this, and have the issues been resolved as we have presented them to the gentleman?

Mr. THOMAS. Mr. Speaker, will the gentlewoman yield?

Mrs. ROUKEMA. I yield to the gentleman from California.

Mr. THOMAS. I would respond that, yes, the issues have been resolved.

Mrs. ROUKEMA. Can the gentleman briefly describe them?

Mr. THOMAS. Yes, I can describe them.

First, we federalize the dual eligibles. We give the governors more than $22.8 billion in additional funds to spend in their States.

Second, the bill allows maximum flexibility to take current State programs and so-called wraparound or integrate them with the Federal program.

But most importantly the legislation creates a commission which is charged with developing a program to address these transitional issues. And it says in the legislation that the proposal must protect current program participants and the financial interests of the States involved. Those States, who on their own offer seniors Medicare prescription drugs should have a special handling to handle the transition with the Federal and the State program.

Mrs. ROUKEMA. I thank the gentleman for his instructions.

Mr. Speaker, another point that I would like made explicitly clear is ensuring that insurance providers will not pull out of an area, leaving seniors without any coverage. As you know, in New Jersey and other areas, HMOs participating Medicare Plus Choice have been leaving the program leaving many seniors without coverage. It is my understanding that under the bill, that at least two insurance providers must be available in each area. To ensure that at least two providers are always available, the government will step in and reimburse providers at a higher rate if necessary to make sure they are available to seniors. I would like reassurance from the Chairman that under this bill, seniors will not have to worry that HMOs will leave the program leaving them without any coverage.

Mr. THOMAS. Mr. Speaker, my answer to the Gentlelady from New Jersey is that this bill guarantees that at least two plans will be available in each area.

In fact, the Medicare Benefits Administrator would administer the program in a manner such that all eligible individuals would be assured of the availability of at least two qualifying plan options in their area of residence, at least one of which is a drug plan. If necessary to ensure such access, the Administrator would be authorized to provide financial incentives, including the partial underwriting of risk, for a PDP sponsor to expand its service area under an existing prescription drug plan to adjoining or additional areas, or to establish such a plan (including offering such plan on a regional or nationwide basis).

It would be written in the statute that all participating seniors will be guaranteed at least two plans from which to choose. I thank the Gentlelady for seeking this important clarification.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. WAXMAN), who was denied, along with the rest of the Committee on Commerce, the opportunity to discuss this matter in committee through this irregular process.

Mr. WAXMAN. Mr. Speaker, I thank the gentleman from Michigan for yielding me this time.

The bill the Republican leadership in this House has insisted on bringing to the floor today is a sham. It purports to provide drugs for the Medicare population. It does not. It purports to give seniors peace of mind that their drug costs will be covered. It does not. It claims to cover the drugs they need, and it does not do that.

Instead, it would allow insurance companies to establish restrictive formularies and use that as a barrier in the way of patients getting medically necessary drugs if those drugs are not on the formularies. It would not assure that Medicare beneficiaries could get their drugs from their neighborhood drugstore. It would not assure that coverage was available in every area of the country. Seniors in rural areas would be particularly likely to find no coverage is available to them.

What does the Republican bill do if it does not spend money to give seniors a drug benefit? It gives money to America's insurance companies. It tries to bribe them into offering an insurance policy that covers just drugs. The companies say they cannot cover just drugs. It will not be affordable, and it will not be available.

Evidently, our Republican colleagues still regret that we passed Medicare. If they had their way, they would design Medicare the way they have this drug plan: use taxpayer dollars to pay insurance companies, and then cross their fingers and hope the insurance companies will provide health care to America's seniors and disabled people.

No guaranteed benefit, differing premiums all over the country, no guarantee of affordability or availability and no accountability. America's seniors would not have wanted that from Medicare, and they will not be fooled by a sham plan for drug coverage now.

What we are seeing here is really about a difference between Democrats and Republicans on Medicare. Democrats know Medicare works. We do not want to throw it out. We want to make it better. We want to add to Medicare a real, defined, guaranteed prescription drug benefit.

We want a benefit that's available wherever you live in this country, whatever your income, whether you're sick or not, whether you're in traditional Medicare or in managed care.

Republicans want to go back to the days before Medicare and tell seniors to depend on private insurance companies.

It they are so sure that's the right way to go, why are they so afraid to let us vote on the plan the Democrats and the President want? Why are they so afraid of adding a real benefit to Medicare for all our senior and disabled citizens?

Mr. BLILEY. Mr. Speaker, I yield 5 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health and Environment of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in support of H.R. 4680, the Medicare RX 2000 Act.

The addition of prescription drug coverage to the Medicare program is one of the most important things we can do this year. I am saddened, Mr. Speaker, by the strictly partisan and political debate that has arisen on this vital issue and by the efforts to continuously interrupt these proceedings with nonsensical procedural motions. This conduct reinforces my sincere belief that the Democratic leadership does not want to take real action this year on this issue, just like they failed to address the problem for over 40 years when they controlled the House.

This is a critical concern for seniors throughout the country, and it should not be reduced to merely a political issue or to one of spite. I am reminded of a debate in the 104th Congress when we worked successfully to save Medicare from bankruptcy. At that time the Democratic leadership exploited the crisis facing Medicare by engaging in demagoguery for political gain. The Washington Post editorial board rightly labeled them ''Medagogues.'' Now they are playing politics with seniors in desperate need of prescription drugs. In the words of the Great Communicator, Ronald Reagan, ''There they go again.''

Many of the latest drug and biological therapies are targeted at preventing or curing diseases that affect senior citizens and persons with disabilities. However, the Federal health insurance program serving these individuals, Medicare, currently, as we know, lacks coverage for most prescription drugs and biologicals. As a result, one-third of Medicare beneficiaries have no drug coverage at all. The two-thirds of beneficiaries who have coverage have to obtain it through a variety of sources, often at considerable expense.

Last year, I introduced legislation to help the neediest and sickest seniors now. The bill before us, although not perfect, helps those seniors in greatest need and those who are the sickest and, thus, has my support. There is always room for improvement, but in the meantime, we can help the most vulnerable seniors now.

This bill includes provisions that I introduced with my colleague, the gentleman from Florida (Mr. SHAW), to ensure access to self-injectable drugs. Currently, Medicare part B only covers drugs that are furnished ''incident to a physician's service.'' In August 1997, however, HCFA issued a memorandum to Medicare carriers stating that Medicare part B would not reimburse for any drugs that were administered incident to a physician's service, if the drugs were capable of being self- injected.

This memorandum, which reversed a previous policy of 30 years, does not take into account the health status of each patient. Many beneficiaries, including cancer and MS patients, are not able to self-inject their necessary medications, even if the drug is normally able to be self-administered. The provision included in H.R. 4680 guarantees the Medicare beneficiaries who are receiving lifesaving injectable drugs and biologicals will continue to have access to those therapies under Medicare part B.

It is also important that this reimbursement continue under Medicare part B because the physician's service must also be reimbursed. The bill before us will ensure that patients who cannot self-administer injectable drugs will be able to have those drugs administered by their physician and receive coverage under the Medicare program.

In closing, Mr. Speaker, I want to again emphasize that for 40 years the Democratic leadership, which controlled the House, did nothing to help seniors gain access to prescription drugs. The problem existed then as it does today, and yet they made little or no mention of it. This Congress is working to solve the problem on a bipartisan basis, and I urge Members to demonstrate their concern by voting for a bill which will help beneficiaries in need today.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. WYNN), to join the American Federation of Teachers in opposition to the Republican bill and in support of our bill.

Mr. WYNN. Mr. Speaker, I thank the gentleman for yielding me this time.

I rise in strong opposition to this bill. It is a bad product of a bad process. They shut out the Democrats today from introducing the Democratic alternative, and now they have on the floor essentially a bad bill.

There are two ways to approach this. On the Democratic side, we have an expansion of Medicare, a guaranteed affordable benefit for all seniors who need coverage to help with prescription drugs. On the Republican side, we have a premium-driven system that basically is designed to benefit insurance companies.

Now, I will tell my colleagues why this is problematic. The benefit is not guaranteed. They have a higher deductible. They have a higher premium. As a matter of fact, we do not have a deductible. They have a $250 deductible. It is a bad idea.

We should not put this issue of prescription drug coverage in the hands of the private HMOs, and I will tell my colleagues why. We are already down here concerned about HMOs and are trying to pass a Patient's Bill of Rights, trying to get the right to see a specialist, trying to get the right for emergency care. The same people that are denying those fundamental rights are now going to be handling prescription drug coverage. I do not think that makes a great deal of sense.

I believe we ought to opt for the Democratic alternative and reject the Republican proposal and reject the Republican process.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), a member of the committee.

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman for yielding me this time.

I would like to read from a letter I received recently from a 70-year-old widow who has been widowed for 14 years. She writes, ''I am in pain daily, and I cannot correct this problem because of financial difficulty. I have stopped taking Prilosec, Zoloft, Lossomax, Zanax, and Zocor. I need these drugs filled monthly and simply cannot afford them. I also am in need of a pain pill, and I have not been able to purchase it. I have cried myself to sleep over this dilemma.''

I think if this lady from my district were here today, she would cry to witness this process. Because over and over again Members from the Republican side of the aisle have stood up and talked about how to solve the problem, and over and over again Members from the Democratic side of the aisle have walked to the microphone with nothing more to offer than blasting away at the plan we have tried to put together in a bipartisan fashion.

We have been criticized for partisanship. Early last year the gentleman from California (Mr. THOMAS) and others put together, extended a wide invitation to Democrats to join Republicans to work out a plan. A few Democrats came over. Some of them have stayed with the bipartisan plan. Most of the others have been driven off by leadership, told not to participate with Republicans in writing a bipartisan bill.

Why? It has been obvious from day one. The plan is that the Democrats want power back, and they think the way to get power back is to stop everything that gets done in this House. And so my colleagues on the other side will say anything and do anything to do it, including denying senior citizens prescription drugs, including my constituent's prescription drugs. And she ought to cry herself to sleep over this process.

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There is a heck of a lot more in common between these plans than there is different, and we ought to work on the difference.

What did the AARP say? ''We are pleased that both the House Republican and Democratic bills provide a voluntary prescription drug benefit in Medicare, a benefit to which every Medicare beneficiary is entitled. And while there are differences, both bills describe the core prescription drug benefit in statute.''

The AARP, the most respected seniors' organization in the country, says we ought to work together and stop fighting in a partisan way.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Louisiana (Mr. JOHN) for purposes of debate in support of this legislation, along with the American Association of People with Disabilities, who join in support of the legislation.

Mr. JOHN. Mr. Speaker, I rise today in order to express my frustrations with the consequences of the Republican plan.

Today the last Medicare Choice HMO servicing the seventh district of Louisiana announced they are pulling out. This is not the case unique to Louisiana's seventh district. This is the case all over America, especially in rural America.

In a few short years since inception of this Medicare+Choice, my seniors have been forced to change health services numerous times. The Republican prescription drug proposal would privatize prescription drug coverage in the same manner that Medicare+Choice privatized Medicare health care services. And this plan, too, is doomed to fail.

Why would the Republicans choose to model a failed plan that has failed seniors? A prescription drug benefit is important to all seniors, not just geographically where they are from.

The Democratic plan guarantees all seniors will have equal access to prescription drugs. The Democratic plan guarantees all seniors will pay the same for prescription drugs.

I urge all of my colleagues to join with me in opposing the Republican unrealistic plan and support the Democratic plan.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Georgia (Mr. DEAL).

Mr. DEAL of Georgia. Mr. Speaker, I thank the gentleman for yielding me the time, and I rise in support of this legislation.

Mr. Speaker, most of our lives are regulated by the calendar and the clock. But if my colleagues come to my home and sit at my dinner table, they will soon find that it is the pill box that is both the calendar and the clock.

The reason is that my 93-year-old mother, who had to have one of her legs amputated, lives with us, along with my wife's 86- and 84-year-old father and mother. They have had major surgery, and one suffers from Alzheimer's.

So as my colleagues sit around our table, they will soon see that it is the

pill box that tells us what day of the week it is and what hour of the day, because it is the medication that they must take that keeps them going. So I understand the importance of prescription drugs.

But these three senior citizens who are now members of our family, and we are so pleased to have them, have served over three-quarters of a century as public school teachers in our State of Georgia; and, as such, they earned the right as a part of their retirement to a medical prescription drug program.

One thing that is very important to them is that this Congress not force them to go into a program they do not want. Age and failing health have deprived them of many of their choices, and they want to retain this one to keep what they have.

But, also, one of the things that they are concerned about is that they have lived frugal lives on school teachers' salaries and they do not want catastrophic illness to wipe that out. I am pleased that our plan provides that kind of financial security for them.

So tonight, to Mary, to George, and to Ida Lu, this plan is for them. And do not forget to take your medication, by the way.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from California (Mrs. CAPPS) in support of the legislation. She is joined in support of this legislation by the American Association of University Women.

Mrs. CAPPS. Mr. Speaker, I rise to express my deep disappointment about the bill before us and this process, which does not even allow a vote on an alternative plan.

As a nurse, I would never shortchange seniors out of their prescription drugs. That is what this legislation does. It is an empty bill which will lead to empty pill bottles for seniors across this country. Simply put, this bill sells our seniors short.

Let us pass secure, affordable prescription drug coverage today for all older Americans, not a risky program that subsidizes private insurance companies.

I urge a no vote.

Mr. BLILEY. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. LAZIO) a member of the committee.

Mr. LAZIO. Mr. Speaker, first I would like to congratulate the chairman of the full committee for his leadership in driving us toward a solution. I would like to also thank the gentleman from Texas (Chairman ARCHER) from the Committee on Ways and Mean. I would like to thank all my colleagues on the task force that helped put this together and, in particular, the gentleman from North Carolina (Mr. BURR) who worked so hard on this issue.

Without their leadership and vision, we just simply would not be here today with a bill that will improve the lives of millions of Americans.

Make no mistake about it. We have an opportunity for those who can just lift their eyes up a little bit higher to see to do the fair and right thing for millions of American seniors and disabled.

Mr. Speaker, senior citizens and disabled Americans are being squeezed between fixed incomes and rising drug prices. Every day many of them are forced to maybe a Hobson's choice between a flat line and the bread line, between paying for life-saving medications or next week's trip to the grocery, seniors like 62-year-old Diane, who worry about whether she will be able to keep a roof over her head when she retires in a couple years.

Well, why does she worry? Because Diane has an IRA, a small pension, a number of chronic conditions that include diabetes, high blood pressure, and a degenerative disk disease. Diane's $1,100 per month medication bill will effectively cut her take-home family income in half.

Mr. Speaker, these are the people who are in the fight of their lives to beat chronic and debilitating diseases. It is immoral to add monetary worries to their burden.

Seniors and disabled Americans deserve to live secure lives, to live secure in the knowledge that the drugs that will save them medically do not ruin them financially.

Mr. Speaker, we are now taking action to give them that security. The House bipartisan plan relies on the public-private partnership model that has proven so successful in the past. It is completely voluntary. It provides universal coverage to all Medicare beneficiaries who want it, senior citizens and the disabled alike.

It contains a provision that will prevent financial ruin and will save older and disabled Americans from being thrown into poverty because of unexpected medication costs. It provides incentives to private insurers to offer subsidized drug coverage to the seniors and disabled Medicare beneficiaries. And the block purchasing power created by these new private sector plans will allow discounts of up to 25 percent to be negotiated with drug manufacturers.

Mr. Speaker, for the last 12 years, the State of New York has had its own prescription drug plan. Yet, even a large State like New York cannot implement a program with the same economies of scale and savings that a national plan would provide.

Recent estimates show that between the years 2002 and 2008 this plan could save New York over $1 billion. Mr. Speaker, this is a good plan. It is a plan that helps our seniors and our disabled Americans but in a way that will not spawn bloated bureaucracies, budget-bursting spending, and Government waste.

Let us do the right thing. Let us pass this bill.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Arkansas (Mr. BERRY). He is joined in his opposition to the Republican bill by the National Council of Churches of Christ in America.

Mr. BERRY. Mr. Speaker, I thank the gentleman from Michigan for yielding me the time.

Mr. Speaker, this is a sad day in this House. The reason it is so sad is because the Republicans have presented us with not a bill, not a plan, but a sham that is so bad and so ugly that they do not even want it compared to anything else. We have not been allowed a substitute. We have not been allowed an amendment. And this is a sad thing for the Republicans to do to the good people of this country.

We have real people with real problems and real pain suffering every day because they cannot afford their prescription medicine. The Republican plan is nothing more than an attempt to deceive our senior citizens and protect the outrageous profits of the prescription medicine makers of this country.

It is a shame that we would allow this important debate to take place with no alternatives at all offered. I urge the defeat of the Republican plan.

Mr. BLILEY. Mr. Speaker, I yield 1 minute to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Speaker, I thank the gentleman for yielding me the time.

I rise to enter into a colloquy with the gentleman from Florida (Mr. BILIRAKIS) if he is willing.

Mr. Speaker, access to affordable prescription drugs and health care coverage is a pressing issue for seniors in my district, which is why I support the Medicare Prescription Drug Act.

I recently introduced legislation, H.R. 4753, which will create Medicare Consumer Coalition Demonstrate projects under the Medicare+Choice program. These nonprofit, regional coalitions would boost seniors' purchasing clout by allowing large groups of independent beneficiaries to join together and, through market-driven negotiations, drive down costs.

I would ask the gentleman to review this legislation and to work with me to see that the concepts embodied in the Seniors Health Care Empowerment Act are incorporated into this and other Medicare reform initiatives that we consider in the coming months.

Mr. Speaker, I yield to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Speaker, I appreciate the gentlewoman bringing to my attention and to our attention the innovative legislation which she has recently introduced.

Consumer coalitions could serve a dual purpose by educating the beneficiaries who are negotiating for lower health care costs. I appreciate her comments on the legislation before us and on her legislation, which is an innovative concept. The proposal is certainly worthy of a close review, and I look forward to working with her on this subject in the coming months.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from California (Ms. ESHOO) to discuss matters which she was denied an opportunity to discuss in any appropriate proceeding in our committee.

Ms. ESHOO. Mr. Speaker, I thank the distinguished ranking member of the House Committee on Commerce for yielding me the time.

I want to underscore something today that I think at the base of all of this is enormously sad; and that is, for the people that are tuned in and listening, this indeed is the House of Representatives, the Congress of the United States of America, the freest nation in the world. At the heart of our democracy is debate. And yet, the majority of this House will not and did not allow one side to bring their idea to the floor of the house.

What are they afraid of? I can debate their idea. I do not support many parts of their plan. That is my prerogative on behalf of the people that I represent. I do not think insurance companies should be subsidized in order to bring about a Medicare drug prescription coverage for our seniors.

But I think the saddest part of this today is that they are afraid of our idea. Why be afraid of what this side could bring to the floor of the House?

In addition, I want to correct the RECORD. Democrats did do something. They established Medicare for the people of our great Nation.

Mr. BLILEY. Mr. Speaker, I reserve the balance of my time and suggest that the minority use some more of their time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. STUPAK) to discuss matters that he was denied the opportunity to discuss in this strangled proceeding in our committee.

Mr. STUPAK. Mr. Speaker, I urge my colleagues to reject this Republican non-plan for prescription drug coverage.

The Republican non-plan does not guarantee that seniors will be offered drug coverage. It does not guarantee that seniors in rural areas like I represent will have access to their medications from their local pharmacy or that they will have access to the medications they need.

Instead, the Republican non-plan provides a subsidy to insurance companies so seniors can continue to pay high prices to drug companies for prescription drugs.

Seniors do not want us to give a handout to the insurance and drug companies. They want affordable drugs now.

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Let us stand with America's seniors. Let us support a real benefit for our seniors, not a cash benefit to the drug and insurance companies. This has not been a bipartisan day. The GOP majority will not even allow us a Democratic substitute or even a Democratic amendment to their bill. They will not even debate the merits of a prescription drug coverage policy for our seniors. That is why we have a nonplan before us. It does not guarantee us anything. It does not provide a benefit. It provides nothing for our seniors.

The SPEAKER pro tempore. Mr. DINGELL.

Mr. DINGELL. Mr. Speaker, I believe it is customary to refer to a Member as the gentleman from Michigan.

The SPEAKER pro tempore. The gentleman from Michigan.

Mr. DINGELL. Am I incorrect in that, Mr. Speaker?

The SPEAKER pro tempore. The gentleman from Michigan is recognized.

Mr. DINGELL. I thank the Chair for observing the regular order.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. GREEN), since he was denied an opportunity to discuss this matter in our committee.

Mr. GREEN of Texas. Mr. Speaker, I thank my ranking member, the gentleman from Michigan (Mr. DINGELL), for yielding me this time.

Mr. Speaker, I am surprised my Republican colleagues can get up the last couple of hours with a straight face and talk about their bipartisan bill. I rise in opposition to this prescription drug gimmick. It is not bipartisan. They even refused us an option to have a vote on an alternative plan. We should be putting the benefits in the hands of senior citizens and not in the hands of insurance companies. We should be providing a secure and reliable benefit instead of creating a new bureaucratic nightmare, a new Medigap policy for seniors to have to fight with. We should be building Medicare up and not tearing it down.

The Republican bill is flawed. It gives seniors the right to buy an insurance policy. They want prescriptions. They do not want an insurance policy. It allows the insurance companies to limit the number of medications it covers. It restricts them from using their local pharmacy. The Republican bill does nothing but get them past the November elections, but our seniors who built this country, who fought in World War II and the Korean War, they know this is a trick, and they are not going to be fooled by it.

The Republican bill costs seniors more each year and it gives them less. The deductibles can increase leaps and bounds. Our seniors deserve more than a voucher. We know this bill is bad for seniors. That is because it is supported by the pharmaceutical companies who are already charging them millions more than they should.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Florida (Mr. DEUTSCH), to discuss matters he was denied an opportunity to discuss in our committee.

Mr. DEUTSCH. Mr. Speaker, the Republicans have been calling this the Medicare prescription drug legislation. I think it would be more accurately described as the anti-Medicare prescription drug legislation. Essentially, what this legislation would do is destroy Medicare. That is what it does. It changes the entire concept that Medicare has had for over 30 years in this country of a universal health care system. If one makes more than $12,600, they get nothing. So it is welfare for health. The incredible broad-based political support that we have for Medicare in America would be lost if this plan passes. What it also does is effectively creates a voucher system for anyone above that amount of income.

The author of this bill, the chairman of the Subcommittee on Health, has said that our accusations of saying that this is not part of Medicare are not true. Well, this plan is being created that has nothing to do with Medicare, and calling it Medicare does not make it Medicare. If we put the Transportation Department into Medicare, it still would be the Transportation Department. It would not be Medicare. I urge its defeat.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Minnesota (Mr. MINGE).

Mr. MINGE. Mr. Speaker, I would like to thank the gentleman from Michigan (Mr. DINGELL), the ranking member of the Committee on Commerce, for yielding me this time.

Mr. Speaker, I would like to share with my colleagues the position of the Fairness Caucus. The Fairness Caucus is committed to ending the regional disparities that exist with respect to Medicare today. The fact that seniors in some parts of the country are already receiving prescription drugs as a part of Medicare, at no premium cost, while seniors in other parts of the country have to buy prescription drugs with their own dollars, this is fundamentally unfair. People are paying the same amounts in regardless of where they live, but the benefits are different. We must end these regional inequities. The motion to recommit will have language making that commitment in an unambiguous way, and I urge that we support the motion to recommit.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Washington (Mr. BAIRD).

Mr. BAIRD. Mr. Speaker, it is right that this body address the problem of prescription medications. It is far past time. I have worked on this issue since I came to this Congress. But as we do so, we must not make the mistake of perpetuating and exacerbating a fundamental inequity in the Medicare system right now. That inequity is this: although every single American pays into the rate at the same payroll rate, we actually receive differential benefits depending upon where we live, such that small urban, suburban and rural hospitals in my district are closing; people are doing without benefits while beneficiaries elsewhere in the country are receiving prescription drug benefits already.

This is wrong. The Republican bill is a placebo bill. It makes one feel good if they believe in it, but it does nothing of substance. We must redress the inequities in the AAPCC rates.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from North Carolina (Mrs. CLAYTON).

(Mrs. CLAYTON asked and was given permission to revise and extend her remarks.)

Mrs. CLAYTON. Mr. Speaker, I urge Members to vote against this bill because this bill indeed does nothing for seniors in general but particularly for those who live in rural areas. There is a differential for those of us who live in rural areas. Already we have lack of access. This does not indeed provide any additional care for them. This puts into the system the differential that is there now. So I object to this bill because it is bad for rural America.

Mr. Speaker, I urge the rejection of this unfair, insensitive and closed Rule.

Under this Rule, the Democratic Substitute is not allowed. The Democratic Substitute would have provided a guaranteed prescription drug benefit, and that guarantee is vital to any prescription drug plan. Indeed, this Rule does not allow any Substitute. It is unfair, undemocratic and should be rejected.

We must make sure that our Seniors, especially those in Rural communities, are able to obtain medicines essential to a comfortable and pain free quality of life. Many Seniors do not have drug coverage, and they also do not have access to the discounts and rebates that insured people receive. Older Americans and people with disabilities, without drug coverage, typically pay 15 percent more for the same prescription drug as those with insurance. And, that gap is growing.

Uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket. Chronically ill, uninsured Medicare beneficiaries spend over $500 more out-of-pocket than those with coverage. This is true, despite the fact that these ill beneficiaries purchase fewer prescriptions than those with coverage.

Rural beneficiaries are particularly vulnerable. There is a Rural Differential that must be considered and that challenges us to construct a plan that benefits all Seniors. More than half of all Rural elderly live below 200 percent of the Federal poverty level. Rural Medicare beneficiaries are over 50 percent more likely than urban beneficiaries to lack prescription drug coverage for the entire year. Moreover, Rural seniors are less likely to have private Medicare supplemental insurance coverage than their urban counterparts—seventy-five percent to sixty-five percent. Rural seniors are far less likely to have access to Medicare-Choice Plans with drug coverage—seventy-nine percent to sixteen percent. And Rural Seniors will spend more out of pocket for prescription drugs than Urban Seniors—twenty-four percent of Urban seniors will spend more than $500, compared to thirty-two percent of Rural seniors. Therefore, any prescription drug legislation, before it can be said that it helps our Seniors, must contain certain basic benefits.

First and foremost, it must be affordable. The proposed legislation fails that test.

Next, it must be available. The proposed legislation fails this test.

Then, the benefits it provides must be set. There must be continuity in coverage. Again, the legislation fails this test.

And, finally, the plan must provide choice. The proposed legislation also fails this test.

While the proposed legislation fails each of these tests for most of our seniors in this Nation, as I indicated, it is especially brutal in its failure to address the needs of our seniors in Rural America. Proportionately, there are more low income senior citizens in Rural America than in any place else in the Country. The high deductibles, combined with the premium payments and the co-payments will discourage many seniors in Rural America from enrolling in the plan.

Subsidies, under the proposal, are provided to insurers rather than seniors, apparently with the hope that premium costs will be lower. That is false hope. And, that false hope is further found in the premise of the proposal that insurers will participate and that seniors will have access to prescription drug plans. There are insurers who choose not to participate in Medigap, and that is especially true in Rural America.

Mr. Speaker, we have a unique opportunity to help millions of our senior citizens with their critically needed prescription medicine. Far too many of our seniors are having to make a choice between the medication that they critically need and other basics, such as food and shelter.

With the essential elements I have described, we can construct a prescription drug plan that helps rather than hurts our seniors. Reject this rule.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from Nevada (Ms. BERKLEY).

Ms. BERKLEY. Mr. Speaker, I thank the distinguished gentleman from Michigan (Mr. DINGELL) for yielding me this time.

Mr. Speaker, I oppose this bill because it fails to provide seniors in my district who are crying out for prescription drug relief with comprehensive coverage under Medicare. I favor a drug plan that is voluntary, affordable and reliable, one in which seniors feel secure and know that the Congress has not abandoned them.

I urge my colleagues to vote against this half-hearted effort and stand up for seniors by demanding a comprehensive drug benefit under Medicare now.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Indiana (Mr. ROEMER).

Mr. ROEMER. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time.

Mr. Speaker, President Harry Truman received the very first honorary card from President Johnson when Medicare was created. We need some Truman honesty about what this bill is about.

Charles Kahn, the president of the Health Insurance Association of America, a group comprised of 294 insurance companies, said this, quote, ''we will withhold judgment on the House Republican bill until we see its details. Nevertheless, we continue to believe that the concept of a so-called drug-only private insurance simply would not work in practice,'' unquote.

I am the first to work in a bipartisan way around here on balancing the budget, reforming welfare, improving education; but a plan has to be given to me that will work.

This will not work. The insurance companies who are getting the subsidy even say it will not work. Mr. Kahn says wait until we see the details.

What is the copay? We do not know. What are the deductibles? We do not know. What are the premiums? We do not know. Let us sit down in a bipartisan way after we reject this plan and work for the senior citizens of this country to get a plan based on Medicare that will work.

Mr. BLILEY. Mr. Speaker, I yield 3 minutes to the gentleman from Tennessee (Mr. BRYANT).

Mr. BRYANT. Mr. Speaker, I thank the gentleman from Virginia (Mr. BLILEY) for yielding time to me.

Mr. Speaker, I too want to add my appreciation for all the hard work that the chairman has done in coming up with this very fine bill.

As I sat here and listened to some of the debate, I realized that talk is cheap but prescription drugs are not cheap. They are expensive and they are getting more expensive every day. Seniors need our help today, not 4 years from now, 6 years from now.

Some of us in Congress have been working together to develop a truly bipartisan plan because there is no role for politics or partisanship in this debate. There should not be.

The health and financial security of millions of our seniors are at stake. And, yes, we do need to tackle and reduce the cost of medicine, but not with a Washington-based one-size-fits-all program.

Every senior is a different person. Every situation is unique, and we must maintain a health care system that recognizes the sanctity of the personal doctor-patient relationship.

Our plan guarantees that every senior, in a big city or in a small town across America, has access to prescription drug coverage under Medicare.

Now, there are several benefits that are unique to our plan. First, our plan gives citizens the right to choose, the right of choice. Seniors will have a choice of at least two plans. Every senior has different health care needs, and that is why they may need different health care plans to choose from. What is more, our plan is completely voluntary, so if a senior likes the coverage they already have, they can stick with it.

Rather than enforcing government price controls, which some would argue in this body, our plan uses group buying power to reduce the costs of prescription drugs by as much as 25 to 39 percent. Millions of these seniors have benefited from these expanded choices and cheaper prices by banding together in private organizations like AARP.

They get all the benefits of Washington-mandated price controls but without rules and regulations and choice limitations and inefficiency.

Seniors who already have that private coverage should also be able to keep it and not be forced into a big government plan. And our plan has always provided real protection from being wiped or having to file bankruptcy because of high prescription drug costs. Once a beneficiary under our plan spends $6,000 out of pocket, she pays not another dime for prescription medicines that year.

Our plan provides beneficiaries with this security and peace of mind while other proposals fall short. The Democrats tried to respond to this part of our proposal, but they have resorted simply to budget gimmickry. We offer this protection now and not in 6 years.

I invite my congressional Democrats to work with us. This should not be a Republican, should not be a Democrat partisan issue. It is an American issue. It is a senior issue.

I urge my colleagues to support this bill so we can give our seniors and the disabled the prescription drug coverage they need now.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Connecticut (Ms. DELAURO). She is joined in her opposition to this outrageous bill by the AFL–CIO and the UAW.

Ms. DELAURO. Mr. Speaker, a month ago the Republican leadership was told by their pollsters that if they did not at least start to sound like they cared about helping seniors with the cost of prescription drugs they would pay a heavy political price. That is why we are here today, saddled with a sham Republican prescription drug bill and a rigged process. The Republican proposal does not provide all seniors with an affordable Medicare prescription drug benefit. It benefits insurance companies. It is complex, takes the very worst from an already failing HMO system. If one needs a medicine that their HMO does not approve, their only recourse is to appeal to the insurance company. My God, we know that that does not work.

Today I was notified by an insurance company that offers Medicare+Choice HMO coverage to seniors in Connecticut that they are no longer going to be able to offer them coverage. Seniors know that they cannot rely on the HMOs, but the Republican leadership is building their plan on this crumbling foundation. The Democratic Medicare prescription drug plan is rooted in the Medicare program that seniors know and trust. It provides affordable, voluntary, dependable coverage, and a guaranteed benefit. It gives seniors security and dignity. Reject the Republican sham bill.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from California (Ms. LEE). She is joined in her opposition to this bill by Americans for Democratic Action.

Ms. LEE. Mr. Speaker, let me thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time and just emphasize my very strong opposition to the Republican prescription coverage plan.

Mr. Speaker, this proposal really claims to help seniors, but in actuality all it really does is help insurance companies. This plan will not guarantee access to coverage, and it will limit seniors' choice of drugs and pharmacies. It could even raise costs for some seniors with medical problems. It is really a sham, and it is a disgrace that the Republicans would not allow a debate on a Democratic proposal which includes a full prescription benefits package including $21 billion in assistance to Medicare health providers and a $3.6 billion rural health package.

Why do we want to have our seniors to be subjected to have to deal with the HMOs and the insurance companies for their medications when these for-profit businesses have really been an impediment to quality patient care for our senior citizens? Our seniors do deserve better. Let us go back to the drawing board. Let us allow for a full debate, one that really does make sense, which will help all of our seniors ensure that they live a safe and sound, long, healthy life.

□ 1645

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I come to the floor on behalf of the seniors in my district who demand affordable, comprehensive, prescription drug coverage to ask what are you afraid of. Instead of debating this very serious issue, we are playing election-year politics with the health of our parents and grandparents, like my 94-year-old grandmother.

What are my colleagues afraid of? The only plan we will consider today throws money at special interests. It is a plan that subsidizes the very same private insurance companies that have fought our efforts to hold them accountable, and allows for pharmaceutical companies to continue their current price gauging.

What are my colleagues afraid of? My constituents demand an answer.

Mr. BLILEY. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. STEARNS), a member of the committee.

Mr. STEARNS. Mr. Speaker, in response to the last speaker, I hope she has a chance just to listen. I have here a letter from Governor Tommy Thompson who talks about this particular bill, and lauds the bill and says it is very important that Congress pass this bill.

I hope the gentlewoman from Wisconsin (Ms. BALDWIN) will take some time this afternoon and perhaps read what Governor Thompson says about this from her State. I would be glad, if the gentlewoman wants to, the gentlewoman can come up now, if she has an urgent need to read this letter.

Mr. Speaker, I say to the gentleman from Michigan (Mr. DINGELL) who is talking about bipartisanship, we have three times as many people who are going to vote for our bill than voted and supported the gentleman's bill that the gentleman called bipartisan last year dealing with managed care.

I think when we talk about bipartisanship, at least we have three times the weight of power to say it is bipartisan than the gentleman did.

Mr. Speaker, I rise obviously in support of H.R. 4680, the Medicare Prescription Act of 2000. Our plan is market based, this is the key, rather than relying upon a government-run program, like many of the Democrats have proposed time and time again.

My colleagues might ask themselves, why is this so important, because we know that one of the overwhelming components of any plan that we offer that it must provide individuals with choice. Joshua Hammond wrote a great book on the seven cultural forces that define who we are as Americans, and the number one item is choice.

Choice must be the centerpiece of anything we propose, and that is why as Republicans and some of the Democrats on that side who agree have joined us.

Our bill fosters competition by empowering individuals with buying power, and it encourages consumers to spend health care dollars much more efficiently than the Democrat plan.

Here is the key. It guarantees Medicare beneficiaries Nationwide that they would have access to at least two competing prescription drug plans. Let me repeat that, not just one, it is choice, but two competing prescription drug plans. To ensure that rural areas are not underserved, the plan must also offer local pharmacy access, insuring that drugs would be available for seniors in rural areas and not just through the mail.

Recently in the press, the human genome project has been all over the front pages. It has now completed its work. The medications that will come on the market in the future as a result of the scientific breakthroughs that will occur because of the genome project will be prodigious, those will be available to Medicare with the passage of this bill.

The real question my colleagues and our seniors should think about, here is what they are faced with. Who do they trust? That is the key question. Who do they trust with their prescription drug plan? Do they want to make their own choices and control the money that they spend, or do they want the government, the United States Government-run plan that leaves them without any say so on what works best for them?

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from Florida (Ms. BROWN).

Ms. BROWN of Florida. Mr. Speaker, I speak from Florida, and let me just say to my colleague from Florida (Mr. STEARNS), we are being hurt most by this, not one program left in your county in Marion County. This Republican bill is a slap in the face to every senior citizen struggling to pay for a needed medicine.

The leadership of this House does not support this bill, they never have. They do not support Medicaid. In fact, in 1995, they said they hoped it would wither on the vine. A zebra cannot change its stripes, Mr. Speaker, and the American people are not buying this sham.

American seniors deserve a program that works. This is a life-threatening situation. This is a hollow bill, vote no.

Mr. BLILEY. Mr. Speaker, how much time is remaining?

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Virginia (Mr. BLILEY) has 6½ minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 12 minutes remaining. The gentleman from Virginia has the right to close.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), who is joined in her opposition to this outrageous bill by the National Medical Association.

Mrs. CHRISTENSEN. Mr. Speaker, I rise as a family physician who has taken care of seniors on Medicare and worked with them as they tried unsuccessfully to stretch their limited funds to purchase the medications they needed.

H.R. 4680 does not represent prescription coverage for all seniors, at best it is an initial misstep to jeopardizing Medicare completely through privatization.

The leadership of this body is doing a disservice by not even allowing the Democratic alternative to the floor for debate.

I ask my colleagues to reject H.R. 4680, and I ask our colleagues to work with us to give our older citizens the kind of help they deserve and the medication they need and support the Democratic proposal.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from North Carolina (Mr. PRICE).

Mr. PRICE of North Carolina. Mr. Speaker, any prescription drug benefit worthy of the name will provide a defined benefit as part of Medicare. It must be available to all seniors who wish to take advantage of it. The Republican plan does not measure up. It simply throws some taxpayers' money at some insurance companies in the hopes they will offer affordable coverage.

It just will not work. The national president of Blue Cross/Blue Shield recently said, ''This idea provides false hope to America's seniors because it is neither workable nor affordable.''

The Republican plan also defies logic. To get $1,000 worth of prescription drug coverage a senior would have to pay $1,070. Who is going to do that? Who wants to pay more to get less? Certainly not my constituents.

The 1.1 million Medicare beneficiaries in North Carolina deserve a real prescription drug benefit, and it is outrageous that through partisan maneuvering we were not even allowed to offer a substitute plan today.

Why are the Republicans scared of a vote? They must know we have a better plan, a real plan, and one that will help seniors get the coverage they need.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, in the dark of night, the Republican Majority's Committee on Rules voted for nothing for American seniors. However, I refuse today to add to their farce by voting again for nothing. I will not vote for this Republican bill that provides no prescription drug benefit for the seniors in my district.

I will not support the continuance of the travesty of seniors having money only to pay for rent and food and dying because they cannot pay for their needed prescription drugs. The Democrats have a plan that has no deductible, a plan that will allow a minimum premium of $25, and cover $2,000 of costs. In my own community, HMOs and health coverage insurance companies have jumped up and run out of town, or simply shut down. I will not condemn my seniors to dialing a phone number to some insurance company and there is a busy signal because that insurance company refuses to cover the costs of the prescription drugs. This Republican bill is a sham, vote it down and get on with the work we should do, provide a guaranteed drug prescription plan for America's Seniors as the Democrats' plan provides.

Mr. Speaker, I rise to respond to this newest attempt by the majority to mislead this nation's seniors into the belief that they are truly concerned about prescription drug coverage.

What the majority is proposing today fails as a legitimate response to the Democrats longstanding position that America's seniors need a comprehensive drug benefit.

Today, the elderly constitute 13 percent of the population, yet account for more than one-third of the nation's annual drug expenditures.

Since 1968, the percentage of seniors' expenditures on prescription drugs has risen from $64 annually to $848 annually which amounts to 4.1 percent of their incomes.

Additionally, despite the fact that 65 percent of the 39 million beneficiaries have some private or public coverage many still do not have adequate supplemental coverage for drug costs.

To address this gap in medical coverage for our nation's elderly, President Clinton proposed a Medicare reform plan, but at that time, the Republicans felt that addressing this issue was not politically expedient.

Yet, in light of the hotly debated Presidential and Congressional races, it appears that the Republicans have suddenly gotten religion!

This latest ''revelation'' by the majority is not even that, in fact, this bill is merely a revelation that the polls indicate it is politically necessary for Republicans to at least address the issue of prescription drug benefits, even if their bill is void of any real relief for this nation's seniors.

Senior and consumer advocates groups alike oppose the majority's Prescription Drug bill because it is fundamentally at odds with any meaningful prescription drug bill.

Groups like the National Council of Senior Citizens, the National Committee to Preserve Social Security and Medicare and Families USA, the National Senior Citizens Law Center, and the American Association of People with Disabilities oppose the majority's plan.

We must pay attention to this nation's seniors when they tell us that the majority's Rx 2000 Act risks the health and well being of not only seniors, but also people with disabilities.

It is particularly enlightening when the head of the Health Insurance Association of America even admits that the Republican's concept of a ''so-called drug-only private insurance simply would not work in practice.''

The seniors living in the 18th Congressional District of Texas located in the City of Houston want real relief from the high price of prescription drugs. They have always told me that you have to watch what someone does, not what they say, in order to know what kind of person you are dealing with.

Let me tell you what you are dealing with under the Republican plan because to hear it from their mouths one would believe that all this nation's seniors and the disabled would be provided with the prescription drug coverage they need . . . however, that is not the case.

The Democratic prescription drug plan is secure because it is part of the Medicare system. However, the Republican scheme relies on private insurance.

The Democratic plan provides comprehensive coverage through the Medicare program while the Republican scheme hopes the private insurers will provide these benefits. Can we really trust such a scheme that is based on the profit of big insurance companies that are in the business to make money without regard to affordability or reliability.

The biggest issue in the debate on a Medicare drug plan is how much will seniors be required to pay out of pocket in order to receive this benefit. Under the Democratic plan there is no deductible, while the Republicans want our nation's elderly to pay $250 a year. If the household were two elderly people than they would be expected to pay $500 a year in medical prescriptions before they earn their benefit to prescription medicines.

Under the Democratic plan, Medicare will pay half the costs of medicines up to $2000 and by the year 2009 Medicare will pay half of all prescription expenses for seniors up to $5000.

The Republican's will only pay half the cost of medicines up to $2100, increasing at the rate of inflation in drug prices. Under the Democratic plan you can see that the real meaning of catastrophic is understood to be a great often, sudden calamity, which ordinary people could not possibly plan to overcome without assistance.

For this reason, the democratic plan has a catastrophic benefit limit of $4,000, after which Medicare pays all costs. Unfortunately, the

Republicans have a total life time limit of $6,000.

I am disappointed that the needs of seniors is not at the top of the House's legislative agenda for consideration of a bill that should have addressed the life and death issue of affordable prescription medication, especially for our nation's elderly poor.

Therefore, I ask that, my Colleagues on both sides of the isle use reason and right mindedness to find the best road to a real prescription for what is ailing our nation's Medicare System, which every American knows is affordable prescription medication for our nation's seniors.

Our nations' elderly have given to this nation the opportunity to successfully compete in today's ever-changing world, which has lead to great economic prosperity for all of us.

Now that our economy and our nation's people are in a position to reap benefits, that are far in a excess of our current needs, we should not hesitate to provide those benefits, which are needed by our nations disabled and senior citizens.

This is a small investment for our nation so that our society can benefit from a healthier senior population, which happens to be a vital and growing sector of our nation's economy.

It is a fact that the baby boomer generation who will be retiring over the next decade will be the wealthiest group of seniors in our nation's history. For this reason their long health and active participation as consumers in our nation's economy makes great economic sense.

I urge my colleagues to oppose this critically flawed semblance of a prescription drug plan offered by the majority and support meaningful prescription drug plans to improve the health of our nation's elderly.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Rhode Island (Mr. WEYGAND).

Mr. WEYGAND. Mr. Speaker, I rise in opposition to this proposal, as I did earlier today, as we have been doing all day long today. What has been happening to the American public is outrageous that, indeed, in fact, that the Republicans will propose today a bill that will actually cost us more in the long run, provide us less with prescription drug coverage and do a disservice to all of our seniors.

I ask all of our Members to vote no on the bill. I ask all of our Members not to even entertain any inkling of an idea that this will be good for our senior citizens, and I hope that all of us will be able to come back with a real bill for prescription drug coverage that will be part of Medicare, not part of a bailout for insurance companies.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. MENENDEZ).

(Mr. MENENDEZ asked and was given permission to revise and extend his remarks.)

Mr. MENENDEZ. Mr. Speaker, as Republicans deny us a chance to offer real prescription benefit under Medicare, I think of my mother and the millions of seniors like her across this country who may not understand Washington politics, but know all too well the every day struggle to buy their medications. Like so many seniors, my mother relies solely on her Social Security benefit, and yet her drug costs totals more than half of her monthly income.

Mr. Speaker, very simply stated, the Republican plan is the first step towards privatizing Medicare and denying Democrats the opportunity to provide the only real Medicare benefit.

Mr. WEYGAND. Mr. Speaker, I raise a point of order. I object to the use of this exhibit that is here. Pursuant to clause 6 of rule XVII, I object to the use of this exhibit by the gentleman from New Jersey (Mr. MENENDEZ).

The SPEAKER pro tempore. Under the rule, the Chair will put the question to the House. The question is: Shall the gentleman from New Jersey (Mr. MENENDEZ) be permitted to use the exhibit?

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. WEYGAND. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 371, nays 48, not voting 15, as follows:

[Roll No. 352]

YEAS—371

Abercrombie
Ackerman
Aderholt
Andrews
Armey
Baca
Bachus
Baird
Baker
Baldwin
Ballenger
Barcia
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Bereuter
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop
Blagojevich
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bono
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Brown (FL)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Cardin
Carson
Castle
Chabot
Chambliss
Chenoweth-Hage
Clay
Clement
Clyburn
Coble
Collins
Combest
Condit
Conyers
Cooksey
Costello
Coyne
Cramer
Crowley
Cubin
Cummings
Cunningham
Davis (FL)
Davis (VA)
Deal
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Diaz-Balart
Dickey
Dicks
Dixon
Doggett
Dooley
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Engel
Eshoo
Etheridge
Everett
Farr
Fattah
Fletcher
Foley
Forbes
Ford
Fossella
Fowler
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goode
Goodlatte
Gordon
Goss
Graham
Granger
Green (WI)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Herger
Hill (IN)
Hill (MT)
Hilleary
Hilliard
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Horn
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Istook
Jackson (IL)
Jefferson
Jenkins
John
Johnson (CT)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kingston
Kleczka
Klink
Knollenberg
Kolbe
Kucinich
Kuykendall
LaFalce
LaHood
Lampson
Lantos
Largent
Larson
Latham
LaTourette
Lazio
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Luther
Maloney (NY)
Manzullo
Martinez
Mascara
McCarthy (MO)
McCollum
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McKinney
McNulty
Meehan
Meeks (NY)
Menendez
Metcalf
Millender-McDonald
Miller (FL)
Miller, George
Minge
Moakley
Mollohan
Moore
Moran (KS)
Morella
Myrick
Nadler
Napolitano
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Ose
Owens
Oxley
Packard
Pallone
Pascrell
Pastor
Paul
Payne
Pease
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pickett
Pitts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Rahall
Ramstad
Rangel
Regula
Reyes
Reynolds
Riley
Rivers
Rodriguez
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Royce
Rush
Ryan (WI)
Ryun (KS)
Sabo
Salmon
Sanchez
Sanders
Sandlin
Sanford
Sawyer
Saxton
Scarborough
Schaffer
Schakowsky
Scott
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stark
Stenholm
Strickland
Stump
Stupak
Sununu
Talent
Tauscher
Tauzin
Taylor (NC)
Thompson (CA)
Thompson (MS)
Thornberry
Thune
Thurman
Tiahrt
Toomey
Traficant
Turner
Udall (CO)
Udall (NM)
Upton
Velazquez
Visclosky
Vitter
Walden
Walsh
Wamp
Waters
Watkins
Watt (NC)
Watts (OK)
Weiner
Weldon (FL)
Weller
Wexler
Whitfield
Wicker
Wilson
Wise
Wolf
Woolsey
Wynn
Young (AK)
Young (FL)

NAYS—48

Allen
Baldacci
Barr
Bentsen
Bonior
Brown (OH)
Capuano
Clayton
Coburn
Cox
Danner
Davis (IL)
Deutsch
Dingell
Emerson
English
Evans
Ewing
Green (TX)
Hefley
Hooley
Hutchinson
Jackson-Lee (TX)
Kanjorski
Kelly
Matsui
McCarthy (NY)
McDermott
Meek (FL)
Mica
Miller, Gary
Mink
Murtha
Neal
Radanovich
Sherwood
Slaughter
Sweeney
Tancredo
Tanner
Taylor (MS)
Terry
Thomas
Tierney
Towns
Weldon (PA)
Weygand
Wu

NOT VOTING—15

Archer
Cook
Crane
Edwards
Filner
Goodling

Kasich	McIntosh	Stearns
Maloney (CT)	Moran (VA)	Vento
Markey	Pelosi	Waxman

□ 1718

Mrs. EMERSON and Messrs. COBURN, MICA, ENGLISH, BARR of Georgia, and TOWNS changed their vote from ''yea'' to ''nay.''

Ms. LEE, Ms. BROWN of Florida, Ms. ESHOO, and Messrs. GEJDENSON, HOLDEN, MCNULTY, MCGOVERN, PALLONE, DEFAZIO, MENENDEZ, GEORGE MILLER of California, JEFFERSON, RUSH, OWENS, LAHOOD, and PAYNE changed their vote from ''nay'' to ''yea.''

So the gentleman was permitted to use the exhibit in question.

The result of the vote was announced as above recorded.

PERSONAL POINT OF PRIVILEGE

Mrs. EMERSON. Personal point of privilege, Mr. Speaker.

The SPEAKER pro tempore (Mr. LAHOOD). The gentlewoman from Missouri will state it.

Mrs. EMERSON. Mr. Speaker, is that poster eligible to be displayed on the House floor? Can the Speaker answer my question as to whether or not the quote that is in poster form on the other side of the Chamber is going to be allowed in the Chamber here to be shown to everybody? Because if the Speaker is going to allow that, then I would like to make a clarification on one point in that quote.

Mr. KLECZKA. Regular order, Mr. Speaker.

Mr. FRANK of Massachusetts. Regular order.

Mrs. EMERSON. Point of personal privilege, Mr. Speaker.

The SPEAKER pro tempore. The gentlewoman will suspend.

By the previous vote of the House, the exhibit will be allowed for the gentleman from New Jersey (Mr. MENENDEZ) to finish. He has 15 seconds remaining.

Mrs. EMERSON. Point of personal privilege, Mr. Speaker.

The SPEAKER pro tempore. The Chair will recognize the gentlewoman if she is yielded time, but there is no personal privilege involved here. This is a matter of debate.

Mrs. EMERSON. Mr. Speaker, was my name on the poster?

The SPEAKER pro tempore. By the vote of the House, just the previous vote, the House has agreed to allow the poster to be used.

The gentleman from New Jersey (Mr. MENENDEZ) is recognized to finish his statement before he was interrupted by the previous vote. He has 15 seconds remaining.

Mr. MENENDEZ. Mr. Speaker, the Republican plan is a cruel hoax that fails my mother and seniors across the country. We have one of the largest budget surpluses in our Nation's history, and Republicans would prefer to give it away in tax cuts to the wealthy. But that is not going to help my mother, and it is not going to help the millions of other seniors struggling to buy medications with only their Social Security check for income.

Vote against this unwise, unnecessary, and deceptive plan.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from New York (Mr. CROWLEY), in opposition to the bill, in which he is joined by the Service Employees International Union.

Mr. CROWLEY. Mr. Speaker, I rise in strong opposition to the so-called Medicare prescription drug bill of 2000. This legislation will not provide the necessary drug coverage for my constituents, like Don and Gertrude Schwartz of Long Island City. He is 89 and she is 84 years of age. Today they pay almost $400 for 100 tablets of Prilosec.

Mr. Schwartz writes, ''Isn't that an outrageous price for a medication my wife will have to take on a regular basis?'' Yes, Mr. Schwartz, it is. Unfortunately, his concerns will not be addressed by this legislation today. This measure will do nothing to assist middle class seniors like the Schwartzes, but then again, our Republican colleagues have never been fans of the Medicare program.

This legislation subsidizes insurance companies and threatens the stability provided to seniors by Medicare. I urge all Members to oppose this sham of a bill.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Massachusetts (Mr. OLVER), who is joined in his opposition to this outrageous bill by the United Steelworkers of America.

POINT OF ORDER

Mr. WEYGAND. Mr. Speaker, I raise a point of order.

The SPEAKER pro tempore. The gentleman from Rhode Island will state his point of order.

Mr. WEYGAND. I object to the use of this exhibit, Mr. Speaker, pursuant to clause 6 of rule XVII.

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that during consideration of H.R. 4680, all Members be permitted to use exhibits in debate.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mr. WEYGAND. I object, Mr. Speaker.

The SPEAKER pro tempore. The Chair did hear an objection.

The question is: Shall the gentleman from Massachusetts (Mr. OLVER) be permitted to use the exhibit.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. WEYGAND. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 326, noes 92, not voting 16, as follows:

[Roll No. 353]

AYES—326

Abercrombie	Fletcher	Manzullo
Ackerman	Foley	Martinez
Aderholt	Forbes	Mascara
Allen	Ford	Matsui
Andrews	Fossella	McCarthy (MO)
Baca	Frank (MA)	McCollum
Bachus	Franks (NJ)	McCrery
Baird	Frelinghuysen	McDermott
Baldacci	Frost	McGovern
Baldwin	Gallegly	McHugh
Barcia	Ganske	McInnis
Barrett (NE)	Gejdenson	McIntyre
Barrett (WI)	Gephardt	McKeon
Bartlett	Gibbons	McKinney
Barton	Gilchrest	McNulty
Becerra	Gillmor	Meehan
Bereuter	Gilman	Meek (FL)
Berkley	Gonzalez	Meeks (NY)
Berman	Goode	Menendez
Berry	Goodlatte	Metcalf
Bishop	Gordon	Millender-McDonald
Blagojevich	Graham	Miller (FL)
Bliley	Green (TX)	Miller, Gary
Blumenauer	Green (WI)	Miller, George
Blunt	Gutierrez	Minge
Boehlert	Hall (OH)	Moakley
Boehner	Hall (TX)	Mollohan
Bonilla	Hansen	Moore
Bonior	Hastings (FL)	Morella
Bono	Hastings (WA)	Nadler
Borski	Hayes	Napolitano
Boswell	Herger	Neal
Boucher	Hill (IN)	Nethercutt
Boyd	Hill (MT)	Northup
Brady (PA)	Hilliard	Norwood
Brown (FL)	Hinchey	Nussle
Brown (OH)	Hinojosa	Oberstar
Bryant	Hobson	Obey
Burton	Hoeffel	Ortiz
Buyer	Hoekstra	Ose
Callahan	Holden	Owens
Calvert	Holt	Oxley
Camp	Hooley	Pallone
Campbell	Horn	Pascrell
Cannon	Hostettler	Pastor
Capps	Houghton	Payne
Cardin	Hoyer	Pelosi
Carson	Hunter	Peterson (MN)
Chabot	Hutchinson	Petri
Chambliss	Inslee	Phelps
Clay	Istook	Pickett
Clayton	Jackson (IL)	Pomeroy
Clement	Jackson-Lee (TX)	Portman
Clyburn	Jefferson	Price (NC)
Coble	Jenkins	Pryce (OH)
Coburn	John	Quinn
Combest	Johnson (CT)	Rahall
Condit	Johnson, E. B.	Ramstad
Conyers	Johnson, Sam	Rangel
Costello	Jones (NC)	Reyes
Coyne	Jones (OH)	Reynolds
Cramer	Kaptur	Riley
Crowley	Kasich	Rivers
Cubin	Kildee	Rodriguez
Cummings	Kilpatrick	Roemer
Cunningham	Kind (WI)	Rothman
Danner	King (NY)	Roybal-Allard
Davis (FL)	Kingston	Royce
Davis (IL)	Kleczka	Rush
Davis (VA)	Klink	Ryan (WI)
DeFazio	Knollenberg	Sabo
DeGette	Kolbe	Salmon
Delahunt	Kucinich	Sanchez
DeLauro	Kuykendall	Sanders
Deutsch	LaFalce	Sandlin
Dickey	LaHood	Sanford
Dicks	Lampson	Sawyer
Dingell	Lantos	Saxton
Dixon	Larson	Scarborough
Doggett	Latham	Schakowsky
Doolittle	LaTourette	Scott
Doyle	Lazio	Serrano
Dreier	Leach	Shays
Duncan	Lee	Sherman
Dunn	Levin	Shows
Edwards	Lewis (CA)	Shuster
Ehlers	Lewis (GA)	Sisisky
Ehrlich	Linder	Skeen
Emerson	Lipinski	Skelton
Engel	LoBiondo	Slaughter
English	Lofgren	Smith (MI)
Eshoo	Lowey	Smith (NJ)
Etheridge	Lucas (KY)	Smith (TX)
Evans	Luther	Smith (WA)
Farr	Maloney (NY)	Snyder
Fattah		

Spratt	Thune	Waters
Stabenow	Thurman	Watt (NC)
Stearns	Towns	Waxman
Stenholm	Traficant	Weiner
Strickland	Turner	Weller
Stump	Udall (CO)	Wexler
Stupak	Udall (NM)	Wilson
Sweeney	Upton	Wise
Talent	Velazquez	Wolf
Tauscher	Visclosky	Woolsey
Tauzin	Vitter	Wynn
Taylor (MS)	Walden	Young (FL)
Thompson (CA)	Walsh	
Thompson (MS)	Wamp	

NOES—92

Armey	Hulshof	Ryun (KS)
Baker	Hyde	Schaffer
Ballenger	Isakson	Sensenbrenner
Barr	Kanjorski	Sessions
Bass	Kelly	Shadegg
Bentsen	Largent	Shaw
Biggert	Lewis (KY)	Sherwood
Bilbray	Lucas (OK)	Shimkus
Bilirakis	McCarthy (NY)	Simpson
Brady (TX)	Mica	Souder
Burr	Mink	Spence
Canady	Moran (KS)	Stark
Capuano	Murtha	Sununu
Castle	Myrick	Tancredo
Chenoweth-Hage	Ney	Tanner
Collins	Olver	Taylor (NC)
Cooksey	Packard	Terry
Cox	Paul	Thomas
Deal	Pease	Thornberry
DeLay	Peterson (PA)	Tiahrt
DeMint	Pickering	Tierney
Diaz-Balart	Pitts	Toomey
Everett	Pombo	Watkins
Fowler	Porter	Watts (OK)
Goss	Radanovich	Weldon (FL)
Granger	Regula	Weldon (PA)
Greenwood	Rogan	Weygand
Gutknecht	Rogers	Whitfield
Hayworth	Rohrabacher	Wicker
Hefley	Ros-Lehtinen	Wu
Hilleary	Roukema	

NOT VOTING—16

Archer	Filner	McIntosh
Bateman	Gekas	Moran (VA)
Cook	Goodling	Vento
Crane	Kennedy	Young (AK)
Dooley	Maloney (CT)	
Ewing	Markey	

□ 1747

Mrs. MYRICK and Mrs. KELLY changed their vote from ''aye'' to ''no.''

Mr. TAYLOR of Mississippi and Mr. GEORGE MILLER of California changed their vote from ''no'' to ''aye.''

So the gentleman was permitted to use the exhibit in question.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. LAHOOD). The Chair recognizes the gentleman from Massachusetts (Mr. OLVER) for 1 minute.

Mr. OLVER. Mr. Speaker, the Republican plan is designed to fail because it is a little more than a request for insurance companies and HMOs to provide insurance for prescription drugs for senior citizens.

But, in fact, those HMOs and insurance companies that would provide their plan have already made market decisions to abandon their Medicare HMO program and pull out of virtually every rural and semi-rural area all over America.

Why would they provide this plan? They have said that they will not. Republicans claim that their drug plan will provide choices for senior citizens, but their plan guarantees nothing. What would provide choice for seniors is a simple, straight forward, universal, guaranteed prescription medicine benefit that every American eligible for Medicare can choose. That would provide at least one more choice for every single American than they have today. Vote no on this sham plan.

Mr. BILIRAKIS. Mr. Speaker, I reserve the balance of my time for the same reasons I indicated earlier.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Rhode Island (Mr. WEYGAND).

Mr. WEYGAND. Mr. Speaker, the gentleman from Massachusetts (Mr. OLVER) is correct. What happened with this plan that is before us tonight is it will fail. It will fail because insurance companies are not capable of making sure that our seniors will have prescription drugs at the lowest affordable price.

Just 45 minutes ago, Mr. Speaker, I received this letter from United Health Care of Rhode Island that proved that very same point. They are pulling out of Bristol County, Rhode Island, and telling all of their subscribers they will no longer have coverage at the end of the year.

This is what this plan will do for our seniors with regard to prescription drugs. It will fail as soon as it is passed. That is why we should vote no on this bill.

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) has 6½ minutes remaining. The gentleman from Florida (Mr. BILIRAKIS) has 6½ minutes.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentlewoman from Oregon (Ms. HOOLEY) 1 minute.

The SPEAKER pro tempore. The Chair recognizes the gentlewoman from Oregon (Ms. HOOLEY).

PARLIAMENTARY INQUIRY

Mr. THOMAS. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California for his parliamentary inquiry.

Mr. THOMAS. Mr. Speaker, parliamentary inquiry. Is it permissible under the rules for a member of the minority party to present a chart and then a member of the minority party to object to the member of the minority party presenting a chart?

The SPEAKER pro tempore. The gentleman may object to the use of the chart if he likes.

Mr. THOMAS. Mr. Speaker, my understanding is that the Chair has ruled that, under the rules, a member of the minority party may object to another member of the minority party offering a chart.

The SPEAKER pro tempore. Any Member may object under the rule.

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that, during consideration of H.R. 4680, all Members be permitted to use exhibits in debate.

Mr. WEYGAND. Mr. Speaker, I object.

Mr. FRANK of Massachusetts. Mr. Speaker, reserving the right to object.

Mr. Speaker, I reserve the right to object.

The SPEAKER pro tempore. The gentleman from Massachusetts (Mr. FRANK) is not recognized. There was an objection.

The Chair recognizes the gentleman from Rhode Island (Mr. WEYGAND).

Mr. WEYGAND. Mr. Speaker, I object. I object.

I yield whatever time I may have to the gentleman from Massachusetts (Mr. FRANK).

Mr. Speaker, I reserve the right to object.

Mr. THOMAS. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. Objections was heard. The question is: Shall the gentlewoman from Oregon (Ms. HOOLEY) be permitted to use the exhibit.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. WEYGAND. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

PARLIAMENTARY INQUIRY

Mr. THOMAS. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from California will state his parliamentary inquiry.

Mr. THOMAS. Mr. Speaker, am I permitted under the rules, under parliamentary inquiry, to inform all members of the majority party that the leadership urges a no vote?

The vote was taken by electronic device, and there were—ayes 224, noes 191, answered ''present'' 2, not voting 17, as follows:

[Roll No. 354]

AYES—224

Aderholt	Coyne	Hall (TX)
Allen	Cramer	Hastings (FL)
Andrews	Crowley	Hill (IN)
Baca	Cummings	Hilliard
Baird	Danner	Hinchey
Baldacci	Davis (IL)	Hinojosa
Baldwin	Davis (VA)	Hobson
Barcia	DeFazio	Hoeffel
Barrett (WI)	DeGette	Holden
Barton	Delahunt	Holt
Becerra	DeLauro	Hooley
Berkley	Deutsch	Horn
Berman	Dicks	Hoyer
Berry	Dingell	Inslee
Bishop	Dixon	Jackson (IL)
Blagojevich	Doggett	Jackson-Lee (TX)
Blumenauer	Doyle	Jefferson
Bonior	Dunn	John
Borski	Edwards	Johnson (CT)
Boswell	Engel	Johnson, E. B.
Boucher	Eshoo	Jones (OH)
Boyd	Etheridge	Kanjorski
Brady (PA)	Evans	Kaptur
Brown (FL)	Farr	Kennedy
Brown (OH)	Fattah	Kildee
Camp	Foley	Kilpatrick
Capps	Ford	Kind (WI)
Cardin	Frank (MA)	Kingston
Carson	Frost	Kleczka
Chabot	Gallegly	Klink
Chambliss	Ganske	Kucinich
Clay	Gejdenson	LaFalce
Clayton	Gephardt	LaHood
Clement	Gilman	Lantos
Clyburn	Gonzalez	Larson
Condit	Goodlatte	Lazio
Conyers	Gordon	Leach
Costello	Green (TX)	Lee
Cox	Hall (OH)	

Levin	Owens	Slaughter
Lewis (GA)	Pallone	Smith (MI)
Lipinski	Pascrell	Smith (NJ)
Lofgren	Pastor	Smith (WA)
Lowey	Paul	Snyder
Lucas (KY)	Payne	Spratt
Luther	Pelosi	Stabenow
Maloney (NY)	Petri	Stark
Mascara	Phelps	Stenholm
Matsui	Pickett	Strickland
McCarthy (MO)	Pomeroy	Stupak
McCrery	Portman	Talent
McDermott	Price (NC)	Tanner
McGovern	Rahall	Tauscher
McIntyre	Rangel	Thompson (CA)
McKinney	Reyes	Thompson (MS)
McNulty	Rivers	Thurman
Meehan	Rodriguez	Tierney
Meek (FL)	Roemer	Towns
Meeks (NY)	Rothman	Traficant
Menendez	Roybal-Allard	Turner
Metcalf	Rush	Udall (CO)
Millender-McDonald	Sabo	Udall (NM)
Miller, George	Salmon	Velazquez
Minge	Sanchez	Visclosky
Moakley	Sanders	Walden
Mollohan	Sandlin	Waters
Moore	Sawyer	Watt (NC)
Morella	Scarborough	Waxman
Nadler	Schakowsky	Weiner
Napolitano	Scott	Wexler
Neal	Serrano	Wise
Ney	Shays	Wolf
Nussle	Sherman	Woolsey
Oberstar	Shows	Wynn
Obey	Sisisky	
	Skelton	

NOES—191

Ackerman	Gilchrest	Northup
Archer	Gillmor	Norwood
Armey	Goode	Olver
Bachus	Goodling	Ortiz
Baker	Goss	Ose
Ballenger	Graham	Oxley
Barr	Granger	Packard
Barrett (NE)	Green (WI)	Pease
Bartlett	Greenwood	Peterson (MN)
Bass	Gutknecht	Peterson (PA)
Bateman	Hansen	Pickering
Bentsen	Hastings (WA)	Pitts
Bereuter	Hayes	Pombo
Biggert	Hayworth	Porter
Bilbray	Hefley	Pryce (OH)
Bilirakis	Herger	Quinn
Bliley	Hill (MT)	Radanovich
Blunt	Hilleary	Ramstad
Boehlert	Hoekstra	Regula
Boehner	Hostettler	Reynolds
Bonilla	Houghton	Riley
Bono	Hulshof	Rogan
Bryant	Hunter	Rogers
Burr	Hutchinson	Rohrabacher
Burton	Hyde	Ros-Lehtinen
Buyer	Isakson	Roukema
Calvert	Istook	Royce
Campbell	Jenkins	Ryan (WI)
Canady	Johnson, Sam	Ryun (KS)
Cannon	Jones (NC)	Sanford
Capuano	Kasich	Saxton
Castle	Kelly	Schaffer
Chenoweth-Hage	King (NY)	Sensenbrenner
Coble	Knollenberg	Sessions
Collins	Kolbe	Shadegg
Combest	Kuykendall	Shaw
Cooksey	Lampson	Sherwood
Crane	Largent	Shimkus
Cubin	Latham	Shuster
Cunningham	LaTourette	Simpson
Deal	Lewis (CA)	Skeen
DeLay	Lewis (KY)	Smith (TX)
DeMint	Linder	Spence
Diaz-Balart	LoBiondo	Stearns
Dickey	Lucas (OK)	Stump
Doolittle	Manzullo	Sununu
Dreier	McCarthy (NY)	Sweeney
Duncan	McCollum	Tancredo
Ehlers	McHugh	Tauzin
Ehrlich	McInnis	Taylor (MS)
Emerson	McIntosh	Taylor (NC)
English	McKeon	Terry
Everett	Mica	Thomas
Fletcher	Miller (FL)	Thornberry
Fossella	Miller, Gary	Thune
Fowler	Mink	Tiahrt
Franks (NJ)	Moran (KS)	Toomey
Frelinghuysen	Murtha	Upton
Gekas	Myrick	Vitter
Gibbons	Nethercutt	Walsh
Wamp	Weller	Wu
Watkins	Weygand	Young (AK)
Watts (OK)	Whitfield	Young (FL)
Weldon (PA)	Wicker	

ANSWERED ''PRESENT''—2

Callahan	Wilson

NOT VOTING—17

Abercrombie	Ewing	Martinez
Brady (TX)	Filner	Moran (VA)
Coburn	Forbes	Souder
Cook	Gutierrez	Vento
Davis (FL)	Maloney (CT)	Weldon (FL)
Dooley	Markey	

□ 1813

Mr. SAXTON changed his vote from ''aye'' to ''no.''

Messrs. SNYDER, ADERHOLT, GEORGE MILLER of California, MCDERMOTT, GALLEGLY, and CHABOT changed their vote from ''no'' to ''aye.''

□ 1815

So the gentlewoman was permitted to use the exhibit in question.

The result of the vote was announced as above recorded.

Ms. HOOLEY of Oregon. Mr. Speaker, every senior in the United States that needs a prescription should be able to get it filled, no extra paperwork, no hunting around to find a private insurance company that might be so kind as to decide they are a good enough risk and sell them a policy.

Unfortunately, the bill being rammed through Congress today is all smoke and mirrors.

In this bill, who knows what the premium will be? We do not know. Who knows what the benefit will be? We do not know. Who knows what the co-pay will be? We do not know.

We have seen private insurance companies in the Medicare+Choice plan pull out of areas in Oregon. The insurance companies have said they will not be in this plan. Our seniors are demanding coverage through the tried-and-true insurer that has not failed them, and that is Medicare.

I want to make sure we take care of our seniors. I want to do it in a bipartisan way, but it is very hard to be bipartisan when we cannot get an amendment in, and we cannot get an alternative here.

I urge my colleagues to vote no on this sham of a bill and support real drug benefits for our seniors.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I only ask that my Republican colleagues be honest about the substance and the procedure here tonight. They are not giving us a Medicare prescription drug benefit, and they are not willing to work on a bipartisan basis. They have stopped us from bringing the Democratic plan to the floor, no substitute, no amendments.

All the Republicans are doing is throwing some money at the insurance companies hoping they will sell a drug-only insurance policy that the insurance companies have already told us that they will not sell.

Let us look at this from the point of view of the average American senior. That senior will benefit directly from the Democratic plan and they will get absolutely nothing from the Republican plan.

Seniors know what Medicare is. They get their hospitalization under Part A. They pay a monthly premium through Part B and they get their doctors bills paid.

What the Democrats are saying, very simply, is we will give them a prescription drug benefit in the same way. They pay a modest premium and the Government pays for a certain percentage of their drug bills. The Democrats give them the benefit through Medicare if that is what they want, it is voluntary, and it covers all their medicines that are medically necessary as determined by their doctor, not by the insurance company.

What the Republicans tell them is to go out and see if they can find an insurance policy to cover their medicine. If they cannot find it, tough luck. And even if they do find it, there is no guarantee as to what the monthly premiums are going to be or what kind of medicine they are going to get.

Lastly, Mr. Speaker, and just as important, the Republicans leave America's seniors open to continued price discrimination. We know that our seniors have complained to us about the high cost and about the discrimination, about the prices in Canada versus the prices in Mexico, or the prices that they pay for their pet.

The Republicans do nothing to prevent the drug companies from charging them whatever they want.

Mr. BLILEY. Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan (Mr. UPTON) a member of the committee.

(Mr. UPTON asked and was given permission to revise and extend his remarks.)

Mr. UPTON. Mr. Speaker, I rise in strong support of the bipartisan Medicare prescription drug plan that we are now considering this evening.

No senior citizen should be forced to forego needed medication, take less than the prescribed dose, or go without other necessities of life in order to afford life-saving medication.

I have watched and I have heard stories and seen seniors literally cutting their pills in half so that they can make it last just a little bit longer and at a little bit less cost.

Helping provide this benefit is important. As I have had a whole wave of town meetings across my district earlier this spring, I can remember one man who brought a bag of prescriptions with him and he said, ''Mr. UPTON, I know you are an optimist. Can you get this bill done in 2 weeks, because that is when this prescription is due and when I have to get it renewed?'' And I pledged to him I would work very hard to try to get a bill through this House

this year but, sadly, not within the 2-week time frame that he wanted.

As a member of the House Prescription Drug Task Force, I had several core goals, tests that this bill does indeed meet. First, I wanted to make sure that seniors are not forced into a one-size-fits-all plan run by a distant, faceless, Federal bureaucracy and all that means in rules, regulations, restrictions, and red tape.

Second, I wanted my constituents to have the same type of plan of choice that the President, all of us as Members of Congress, and the rest of the Federal workforce does. I want my constituents to have the ability that I have to select from plans that are competing for premiums on the basis of how well the restraining health care costs, providing access to high quality care.

I urge all Members to support this bipartisan plan.

Mr. DINGELL. Mr. Speaker, I yield the balance of the time to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Michigan for yielding me the time.

Mr. Speaker, I have an idea. What if Congress broke Medicare apart? Congress would tell seniors to look to the private insurance market if they want to piece it back together, the seniors could buy one plan to cover doctors' visits, another plan to cover hospital stays, a third to cover home health services. Perhaps they could purchase an Aetna plan for outpatient care, a Kaiser plan for physical therapy, a Blue Cross plan for medical equipment.

No one in this body, Mr. Speaker, would dare offer a proposal like that because it is simply absurd. But why is it any less absurd to isolate prescription drugs and require Medicare beneficiaries to carry a separate private insurance policy for that benefit?

If the GOP prescription drug plan is a back-door attempt to privatize Medicare, my colleagues should tell us so. If the goal of this Congress truly is to help America's senior citizens, this bill simply is not a real option.

Medicare came into being because half of all seniors could not get coverage. Medicare, a nationwide plan with a risk pool of 39 million strong, is a stable, reliable means of ensuring coverage for our seniors. Medicare works because it guarantees the same basic benefits to all beneficiaries regardless of where they live, regardless of their income, regardless of their social status, regardless of their gender. It is fair.

H.R. 4680 costs $40 billion. Yet, it offers Medicare beneficiaries nothing tangible. Think about the kind of questions seniors might have about this proposal: Will I be able to buy this new coverage? How much will it cost me? How much will the Government contribute on my behalf? Which drugs will my doctor be able to prescribe? Is this new benefit a good deal for me?

Under the Republican proposal, the answer to every one of these questions is ''who knows.'' When we are allegedly addressing the single most important problem for millions of people in this country, that answer, Mr. Speaker, should get them fired.

Vote no on H.R. 4680.

Mr. BLILEY. Mr. Speaker, I yield the balance of the time to the gentleman from North Carolina (Mr. BURR) the distinguished member of the committee who has worked long and hard on this bill.

(Mr. BURR of North Carolina asked and was given permission to revise and extend his remarks.)

Mr. BURR of North Carolina. Mr. Speaker, while we have been here today to debate this bill, many Medicare beneficiaries across this country have taken their medication now for the third time. How long must they wait? The time is right today for us to solve this problem.

Look around us. Look at this Chamber, the power that exists here, the Members before us who have handled the legislation that is so important to the future of this country. I wonder if in the old Statuary Hall just down the hall from here if the words ''sham,'' ''hoax,'' ''dangerous'' were used when they debated legislation that we still look at today that affects our lives.

I do not believe they did. Because there was a spirit then that there were some things that rose above politics. There were some things that were so important for future generations that it bypassed everything.

Thomas Jefferson said, ''I am not an advocate of frequent changes in laws and institutions, but laws and institutions must advance to keep pace with the progress of the human mind.''

It was a message to us. It was a message to America that we have an obligation to revise and update our laws and, importantly, this institution.

This is such an opportunity to take a 35-year-old program and to make an addition that technology has now made possible to be part of that.

Mr. Speaker, it is time for us to see the human face, the seniors, the disabled that qualify for Medicare all across this country that are waiting for us. They are waiting for us to devise a plan. They are waiting for us to create a benefit. I truly believe today that Republicans and Democrats are both trying to supply that benefit. But we have some very stark differences.

The President would like to administer this program through the Health Care Financing Administration. We want to do it through a new entity, not an entity that is bogged down with a system today that they cannot run but with one whose only responsibility it is is to administer and negotiate a drug benefit.

The President wants a one-size-fits-all. We believe that choice is important. Choice is important at HCFA today because they use private-sector insurance companies in Part A and Part B and they have the flexibility in each region to design that benefit to meet the needs of that region.

□ 1830

Mr. Speaker, my mother deserves the passage of this bill. She is one of those seniors that takes quite a bit of medication. Thank goodness she is able to afford it. But she deserves it because she has reached that golden age; and just as much as she deserves it, my children deserve that whatever we do today they can afford tomorrow, and that is why it is so delicate an issue.

Mr. Speaker, this plan makes drug benefits available. It makes them affordable. They are voluntary. It has the security and predictability that seniors need. It has choice and it does not come from that face we know as government.

It will stand the test of time. It will stand the test of the cost; and more importantly, Mr. Speaker, it will stand the weight of a doubling of the senior population in America.

George Bush stood on the steps of this Capitol in 1988, and he said in his inaugural address, we are not the sum of our possessions. They are not the measure of our lives. In our hearts, we know what matters. We cannot hope only to leave our children a bigger car or a bigger bank account. We must hope to give them a sense of what it means to be a loyal friend, a loving parent, a citizen who leaves his home, his neighborhood and his town better than he found it.

Mr. Speaker, as we close in on July 1, the year 2000, the 35th anniversary of the creation of Medicare, I hope it is this body that passes that date, having passed a prescription drug benefit so for the first time seniors in America will have access to affordable drugs for their well-being.

I thank the gentleman from Virginia (Chairman BLILEY) for his help, the gentleman from Texas (Mr. ARCHER), and all the Members that were involved.

Mr. SANFORD. Mr. Speaker, I rise today, with great regret, to oppose H.R. 4680. It's been said that the road to hell is paved with good intentions. If you follow this debate on prescription drug coverage for Medicare beneficiaries you would understand that adage all too well. Throughout the debate, both Republicans and Democrats have tried to gain a political advantage in this election year by offering competing plans that would provide drug coverage. These plans, in the end, represent a bidding war for votes. So while I am the first to recognize the fact that many people need help with prescription drugs, I am not convinced that adding another element to the Medicare program that the Trustees say is going bankrupt is the way to get there. In particular, Washington's current proposals have two problems: 1. It does little good to add prescription drugs to Medicare if it still goes bankrupt, and 2. Both plans, particularly the President's leaves room for this ''cure'' to get much more expensive.

First, let's identify the problem. Today, one out of every three seniors does not have any prescription drug coverage. Compounding that problem is that prescription drug costs have increased an average of 12.4 percent annually, while overall health care spending has increased by 5 percent. The average senior

spends $500 or less each year on prescription drugs. In looking at the proposals, you can see that they we are using shotgun rather than a rifle in our aim to fix this problem. The plans are designed to offer prescription care to all Medicare beneficiaries—including the millionaire widow living in Palm Beach—rather than just those who truly need it, low-income seniors without prescription drug coverage. It's important to focus because, despite current opinion, dollars are limited in Washington.

The House Republican plan is designed to implement a voluntary, market-oriented approach to prescription drug coverage, added as Medicare part D. The Republicans guarantee that each region of the country will have two competing insurance plans from which to choose. The insurance coverage includes a $250 deductible and require seniors to co-pay 50 percent of costs up to $2,100 each year. If a senior's drug costs go beyond $6,000 then the government and insurance pay all of the costs. The new program is projected to cost $37.5 billion over 5 years and $155 billion over 10. However, that projection includes a couple of unlikely assumptions—that there will be no growth in Medicare and that 80 percent of seniors will participate in this program.

Remember, only 33 percent of seniors have no drug coverage and only 28 percent pay more than $500 a year out of pocket. Under this voluntary plan, only seniors with little or no coverage and high prescription drug costs will sign onto this plan. Such enrollment is known as adverse selection and leads to high premiums. This legislation will, in the long run, force the taxpayers to pick up the cost of the increasing premiums. Taxpayers will also have to guarantee the profitability of the insurance plans. If you include adverse selection into the formula, the costs of this prescription drug legislation could go as high as $600 billion over the next 10 years. The financial risks of this bill are just too great. The prescription drug coverage proposal starts looking like the Medicare private insurance plans set up in the Balanced Budget Act of 1997. Many seniors signed up for those plans in the first year, only to see the plans close out the next year.

The President's plan presented different but equally bad options. His plan is optimistically estimated to cost $35 billion over 5 years and nearly $300 billion over 10 years. The prescription drug program would be a part of the current Medicare system, similar to Medicare part B. Monthly premiums begins at $24 and seniors would co-pay 50 percent of prescription drug costs up to $2,000. Premiums would go up to $51 a month for premiums and the ceiling is lifted to $5,000 a year. Again, the proposal is voluntary, so there would also be adverse selection—making premiums again, much more expensive than now advertised.

The problem with this plan is that, like all other portions of Medicare, the government gets to decide how big the benefit and whether or not you even get it. Seniors today can probably already relate to this. Since I came to Congress in 1995, more and more seniors tell me that they can not longer see their doctor simply because they have retired and joined Medicare. Today, Medicare pays 70 percent of what the private sector pays for the same procedure. Since the creation of Medicare in 1965, payments to providers have been cut 14 times, the net result is less access for patients. One can reasonably believe that the same will happen under a prescription drug program. Imagine Congress, trying to save billions of dollars sometime in the future, cutting prescription payments (cost controls) or taking expensive medications off the list of approved medications. The government should simply not be in the business of making those life or death decisions.

At the end of the day, I maintain that Congress and the President should implement a more comprehensive reform bill that gives seniors the power to design their health care coverage. They could choose the type of insurance plan they want, whether or not to have prescription drug coverage, and how much they are willing to share in the cost burden. Such a proposal was offered by the Bipartisan Medicare Commission Co-Chairs Representative BILL THOMAS and Senator JOHN BREAUX. The proposal would use the market place to make a more financially secure and less expensive plan for seniors. Perhaps when the dusts clears and November has passed, calmer heads will prevail.

Mrs. FOWLER. Mr. Speaker, the Medicare Prescription Act of 2000 is of particular importance to me as I represent hundreds of thousands of senior Floridians who are seeing prescription drug costs skyrocket out of control forcing many to choose between food and medicine.

We now have a tremendous opportunity to help millions of senior Americans afford the prescription drugs they need, without jeopardizing the Medicare benefits many already enjoy.

Our bipartisan effort offers the best prescription for America. We strengthen Medicare while providing prescription drug coverage.

More importantly—it is affordable, available, and voluntary for all.

Under this bipartisan plan—seniors will no longer have sticker-shock when paying for their medicine. For the first time, they will have meaningful bargaining power.

Unlike the Clinton/Gore plan—we give all seniors and the disabled the right to choose an affordable prescription drug benefit that best fits their need. They can choose a ''Cadillac'' plan or opt for a more affordable ''Honda'' plan—which ever they need.

We lower costs of prescription drug coverage through group buying power—not by having politicians or federal bureaucrats set their prices. This will reduce prices by an average 25 percent and up to 39 percent. The CBO even estimates we will save seniors twice as much than the Clinton/Gore plan.

Our plan also includes a cap on catastrophic drug costs. This cap on out of pocket expenses at $6,000 a year gives seniors peace of mind—no longer will they be forced to choose between bankruptcy and the drugs they need.

I urge my colleagues to support this important legislation.

Mr. BENTSEN. Mr. Speaker, I rise in strong opposition to H.R. 4680, the Medicare Rx 2000 Act, legislation purporting to provide a new prescription drug benefit for America's senior citizens. I believe that this bill is fatally flawed and should be defeated.

While Medicare has been a tremendously successful program in providing health care for senior citizens and a better quality of life, the rising use and cost of prescription drugs demands congressional action. Prescription drugs now account for about one-sixth of all out-of-pocket health spending by senior citizens. The percent of beneficiaries without coverage who cannot afford to buy their medicine is about five times higher than those with coverage (10 percent compared to 2 percent). Almost 40 percent of those over age 85 do not have prescription drug coverage. H.R. 4680 not only does nothing to address this crisis in health care but also cruelly raises the hopes of America's senior that this problem will be meaningfully addressed.

Specifically, Mr. Speaker, this plan subsidizes insurance companies and sets us on a path of privatizing Medicare. H.R. 4680 provides premium subsidies to insurers but does nothing to ensure that these premium subsidies are passed on to seniors. Moreover, private insurance plans have said that they will not offer this coverage. Scott Serota, acting president of Blue Cross & Blue Shield put it best when he said ''The idea [a private sector drug benefit] provides false hope to America's seniors because it is neither workable nor affordable.'' Thus, the benefits offered are illusory and unstable, and the Republican majority know it. Moreover, even after these large subsidies, there are no guarantees under the Republican plan that seniors can afford to buy this coverage.

As a senior member of the House Budget Committee, I offered a meaningful prescription drug benefit during the markup of the fiscal year 2001 budget. At the time, Chairman KASICH and others committed this effort to devising a budget that sacrifices everything in the name of giving the largest possible tax cuts without doing anything to address the long-term needs of Social Security or Medicare. H.R. 4680 is the unfortunate offspring of budget language that the House Budget Committee adopted and that, at the time, I characterized as mere lip-service to the public's desire for a prescription drug benefit. The budget provision provided for a ''$40 billion reserve'' that, during the Budget Committee markup, was spent several times on prescriptions, Medicare reform, and debt reduction. Today, The Republicans are married to ''$40 billion,'' an seemingly arbitrary number. However, actually the Republicans are putting tax cuts ahead of the needs of seniors.

Both during the budget process and throughout the 106th Congress, I have witnessed the Republican majority purposefully and effectively provide for tax cuts, particularly for the highest income bracket. When it comes to providing for meaningful relief for our seniors, we see this limp halfhearted political measure that in no way guarantees any prescription drug relief for our seniors.

I also believe that this procedure has not provided adequate debate about a critically important issue to 39 million Americans, our nation's senior citizens. Rather than allow an open and honest debate on how the Congress would provide for a prescription drug benefit for America's seniors citizens, the Republicans has scripted a closed rule limited debate,

predicated on an arbitrary budget resolution, which they have shown a willingness, time and again, to violate when it suits their purposes. Unfortunately, both their flawed insurance subsidy plan and their desire to stifle debate in ''The People's House'' on a question of vital importance to nearly 40 million beneficiaries, indicates, once and for all, that responding to the needs of America's senior citizens does not suit the political purpose of congressional Republicans.

The Republicans have designed a flawed plan that delays implementation and limits catastrophic coverage to only those costs that exceed $6,000. Under their plan, if the government pays an insurer enough to create a plan where the premiums are not set too high by the insurer that someone can afford it, you still only get a benefit of about $1,000 less premiums and after that you are on your own until you reach $6,000. The Republicans know full well that a real, affordable, workable prescription drug plan costs more, but they are opposed to investing in this coverage for America's senior citizens.

During the drafting of the FY 2001 Budget Resolution, the Republican majority found room for $175 billion of tax cuts, primarily for upper-income Americans, but said that ''if and when'' a Medicare prescription drug plan could be developed it would have to be limited to $40 billion. There was no study, no scientific basis, no analysis that resulted in this $40 billion figure, rather it was a back of the envelope calculation to make room for the huge tax cut they wanted to fund.

Furthermore, during the markup of the budget resolution, I offered an amendment to restore funding for teaching hospitals, academic medical centers and other Medicare impatient costs. My amendment was rejected and I was told by the Republican majority that any changes to the Balanced Budget Act (BBA) of 1997 could be addressed out of the $40 billion set aside. I was also told that money could be used for Medicare reform. But, of course that's the same money that was supposedly set aside for prescription drug coverage.

Now we hear that the Republican leadership has promised to push legislation later this year to revise the 1997 BBA as it relates to Medicare providers to the tune of $21 billion. But, if we are to abide by the FY 2001 Budget Resolution and adopt the Republican's prescription drug plan, there will be no money left for a BBA fix. Clearly, the Republicans have no intention of abiding by the FY 2001 Budget Resolution so long as it does not serve their political purposes.

This is not a new phenomenon. History shows that when the Republican majority wants to violate the budget resolution, they do it with finesse.

Under the Balanced Budget Act of 1997, Agriculture programs were to be funded at $11.3 billion in 1999 and $10.7 billion in 2000. But, when the time came for Congress to live by these caps, the Republican majority, recognizing the harsh effects these constraints would have on America's farmers, abandoned them. Agriculture was funded at $23 billion in 1999 and $35 billion, more than double the BBA figure for 1999 and nearly three and half times the BBA level for 2000.

When the Republican leadership decided they wanted to spend more, not less, on highway construction, than provided for under the 1997 BBA, they busted the caps. So far, they have funded the Transportation at $40.6 billion in 1999 and $44.3 billion in 2000, $1.7 billion and $5 billion for each year respectively.

Again, when the Republican leadership wanted to increase funding for the Department of Defense, they did not let arbitrary restrictions, in place since the BBA of 1997, hinder them. They increased outlays over the prescribed BBA level for 1999 by $17.1 billion and, for 2000, by $14.5 billion.

Mr. Speaker, don't get me wrong. I do not dispute the need, at times, to adjust BBA caps when the need is justified. What I do challenge is whether the Republican leadership is really sincere about helping America's senior citizens. They found a way to finesse budget limits for national Defense, for highways and for our struggling farmers. These are all worthy causes, but why won't they work around the budget resolution for America's senior citizens? Why won't they do this for the generation that fought ''The Great War'' and built the nation? Why won't they do this for those we honored this past week, who fought the ''Forgotten War'' in Korea?

If the Republicans were really sincere about helping our seniors, they would not hide behind artificial budgets and stifle debate. They would allow the Democrats, who started this debate in the first place, to bring up our bill which provides for meaningful, voluntary, universal prescription drug coverage under Medicare.

Let us have the debate on what is best for senior citizens, even if it means debating a real drug benefit versus large tax cuts. But, let us have the debate.

I am strongly supporting the Democratic alternative legislation that would provide meaningful, comprehensive prescription drug benefits for our nation's senior citizens. The Democratic plan provides better benefits at a lower cost for the elderly. It includes zero deductible and a premium of $25 per month in 2003. It also includes subsidized premiums for low-income seniors who may have difficulty paying these premiums. The Democratic plan provides immediate coverage for prescription drugs starting in 2003, rather than the delayed implementation included in the Republican plan. The Democratic plan also provides better catastrophic benefits by limiting out-of-pocket expenses to $4,000, a full $2,000 lower than the $6,000 limit included in the Republican plan.

The Democratic plan would also provide $21 billion in relief to rural and urban hospitals, nursing homes, home health agencies, and other health care providers who have faced difficulties due to the reductions included in the Balanced Budget Act of 1997. In my district, many of the teaching hospitals at the Texas Medical Center are facing increased pressures to maintain their teaching mission in a time of lower Medicare reimbursements. This comprehensive plan would provide needed revenues to ensure that our health care system remains the envy of the world.

I am disappointed that the Democratic plan will not be considered today and for all of these reasons, I urge my colleagues to oppose this bill.

Mr. GILMAN. Mr. Speaker, I rise today in qualified support of H.R. 4680, the Medicare Rx 2000 Act. I urge my colleagues to carefully consider this issue in making a final decision.

Mr. Speaker, we are all fully aware of the explosion in costs for prescription drugs in recent years. This phenomenon has in part been linked to the rapid proliferation of the number of new drugs that have become available in the past decade. We are currently enjoying a period of revolutionary advances in the fields of medicine and medical technology. Yet, at the same time, a significant portion of our elderly population is unable to benefit from these new advances, due to the high costs that are associated with them. This is ironic, when one realizes that senior citizens are the primary group that these new advances are targeting.

One fact that has become increasingly apparent is that Medicare is woefully inadequate in meeting the medical needs of today's senior citizens. When Medicare was created in 1965, outpatient prescription drugs were simply not a major component of health care. For this reason, Medicare did not provide coverage for self-administered medicine.

Today's health care environment is vastly different from that of 1965. The majority of care is now provided in an outpatient setting, and dozens of new prescription drugs enter the market every year to treat the common ailments of the elderly, including cancer, heart disease, arthritis, and osteoporosis.

But while the health care environment has made remarkable progress since 1965, Medicare has stood in place. Consequently, most of my colleagues and I have heard from constituents who are now facing the dilemma of paying for these expensive new drugs while living on a fixed income. The individual who is forced to choose between food and medicine is no exaggeration. It is an all too common occurrence across the country. The high cost of prescription drugs have become a threat to the retirement security of our nation's senior citizens.

It is for this reason that I am pleased to see that the Ways and Means Committee has completed its work on a proposal to provide prescription drug coverage for Medicare beneficiaries. What concerns me, however, is the process by which this measure was brought to the full House for consideration.

Mr. Speaker, the decision to add prescription drug coverage will result in the greatest change in the Medicare Program since its creation. This is not something that should be done lightly or in haste. Given that, I have serious reservations about bringing such major policy-changing legislation to the floor for final passage less than 3 weeks after it was introduced.

With that said, I would like to comment on the positive points of the bill as well as to highlight some of my specific concerns with the legislation.

In my view, any proposal to offer prescription drug coverage under Medicare needs to contain the following characteristics to be voluntary, to have universal eligibility under Medicare, contain stop-loss protections to guard against catastrophic expenses, offer choices in the type of coverage provided, and remain a good value over time.

The proposal outlined in H.R. 4680 clearly meets these requirements. It differs from the administration's proposal in that it defines the scope of its stop-loss protections, and ties its benefits to medical inflation and the actual costs of the drugs, rather than the Consumer Price Index, H.R. 4680 also avoids a one-size-fits-all government-imposed solution by offering senior citizens a choice in the types of

plans in which to enroll. In doing this, the government will guarantee that at least two plans will be available in every area of the country. Moreover, the proposal fully funds all costs for those enrollees below 135% of the poverty rate, and partially funds the costs of those up to 150% of the poverty rate.

In addition, this legislation also establishes a new agency, the Medicare Benefit Administration, to oversee the implementation of the plans. It further creates an office of beneficiary assistance and Medicare ombudsman to serve as a patient advocate, and mandates the establishment of a policy advisory board much like those for the IRS and Social Security Administration.

As I mentioned, I do have some reservations about certain aspects of this bill. The first of these is the matter of adverse selection. Simply put, this is the condition whereby most seniors in good health avoid signing up for a plan, leaving the majority of enrollees coming from the sickest segment of the population. If this were to occur, the premium and deductibles would have to be far higher than presently outlined.

The bill's sponsors reply that by covering part or all of the costs of those with incomes up to 150 percent of the poverty level, the proposal would ensure that there would be an adequate base of healthy seniors to offset the portion in greatest need of the benefit. This remains to be seen, and I believe that this particular aspect of the plan needs to be monitored closely.

I am also concerned about the viability of private insurers underwriting plans in areas where it is not profitable for them to do so. Recent experience with Medicare+Choice plans in my district have borne out this concern. In such cases, the government would step in as the ''insurer of last resort,'' assuming a share of the risk as well as subsidizing the cost of offering service in a rural area. My chief concern with this is that it has the potential to become a costly venture for the government, where the private insurers deliberately hold out in order to secure a greater level of government funding.

In spite of these concerns, I firmly believe that this legislation is an important first step in providing a benefit to our senior citizens which is long overdue. The prescription drugs situation will not change on its own in the future. Rather, we will continue to see a flood of new revolutionary products hitting the market. However, there is a price to pay for innovation, as our recent experience has shown. In accepting this, it is important that we do not continue to fall into the trap in which we presently find ourselves—having new products that are too expensive for their target audience.

This bill is the first step towards correcting this problem. For that reason, despite my stated reservations, I intend to give it my qualified support. It is my hope that my concerns will be addressed in a future House-Senate conference on this issue. Should this not be the case, I will reconsider my future support when the final compromise language comes before the House.

Regardless of the final outcome, I will not support any legislation which, under the claim of reducing drug prices, denies doctors the ability to prescribe those medicines which they deem best for their patients simply to save money. This is exactly what has happened to the government-run systems in the United Kingdom and Canada.

The relationship between the doctor and patient is sacred and should not be tread upon—especially by any government bureaucrat. This issue is too serious for party politics, and, as I stated at the outset, I urge my colleagues to give it their careful and thoughtful consideration.

Mr. COYNE. Mr. Speaker, I rise today in opposition to the Republican Prescription Modernization Act and in support of the Democratic Substitutes. The Republican bill before us today does not assure all Medicare recipients access to affordable prescription drugs. Seniors have learned that they cannot rely on private insurance plans.

The Democratic Substitute is a true entitlement for Medicare beneficiaries and it would be administrated by Medicare. Under our bill, all seniors are entitled to defined premiums and defined benefits.

Under the Democratic Substitute, seniors are entitled to a prescription drug benefit with a $25 premium and no deductible. The Republican plan offers no defined premium and no fixed deductible. Both of these factors will vary from region to region and from year to year.

I urge my colleagues to vote against the Republican plan with its entitlements for the drugs and insurance industries. The Democratic substitutes is the only plan that entitles seniors to the benefits they deserve. The Republican plan is not an entitlement for senior citizens but an entitlement for insurance companies and pharmaceutical companies.

Mr. Speaker, for these reasons, I urge my colleagues to vote against this bill.

Mr. KNOLLENBERG. Mr. Speaker, I rise in strong support of H.R. 4680, the Medicare Rx 2000 Act, and urge its adoption.

We all know that American society is growing older and there is a lot of discussion about the best way to prepare for this reality. Despite the fact that older Americans make up only 13 percent of our population, this age group consumes more than one-third of the prescription medicines in our country.

The non-partisan Congressional Budget Office recently found that, in three years, the average senior will spend $2,075 annually on medication. Compare that to 1970, a year when surveys revealed that people over the age of 65 spent an average of $56 on prescription drugs. That equates to $247 in today's dollars, which is a mere fraction of the cost citizens are currently paying. This is a steep increase by any measure.

The bipartisan plan we have before us is eminently fair. It provides reasonable choices for consumers. Every consumer is guaranteed a choice of a least two prescription plans. We should reject the 'one size fits some' solution that some Members advocate. I think a recent New York Times (June 18, 2000) subtitle says it all: ''Democrats' Prescription Plan Calls for 'One Size Fits All'—G.O.P. Offers Choice''. The American people saw through this scheme in 1994 when they rejected the Clinton health plan and they do not want to see a repeat of this mentality.

The bipartisan plan ensures that our nation's neediest seniors receive prescription drug coverage. This vital safety net ensures that no one will be left without coverage.

The bipartisan plan fits within the framework of the budget resolution this Congress adopted. I sit on the Budget Committee and we responsibly set aside $40 billion specifically for a prescription drug benefit. In fact, I would remind my colleagues that substitutes offered by the Ranking Democrat on the committee, Mr. SPRATT, and the Blue Dog Coalition both offered $40 billion—exactly the same figure we are using today.

Some Members advocate busting the budget through a $100 bill scheme. Like every household, we have to live within our means, especially since we are at the dawn of the balanced budget era.

With all of the pomp and bluster of the prescription drug issue it is easy to lose sight of the bigger, more important issue: overall Medicare modernization. The bill we have before us is a nice step but we need to do more to address this critical issue. I look forward to the day when we turn our full attention towards saving and strengthening our Medicare system.

I urge a ''yes'' vote on the bipartisan prescription drug plan.

Mr. KILPATRICK. Mr. Speaker, I rise in opposition to the bill, H.R. 4680, the Medicare Drug 2000 Act. I am outraged and frustrated that my colleagues across the aisle gave us no opportunity to vote or debate our Democratic alternative. That is ironic when you consider the opposition likes to champion itself as the party choice; yet, we are denied the opportunity to vote for a different choice today. It is either the Republican plan or no plan. Can it be that they are afraid to have their bill measured against a more affordable and comprehensive prescription drug proposal that Democratic Members sought to offer but were denied by the majority? The Republican plan cannot stand up to the rigors of a full, fair and honest debate.

I oppose the legislation not only on procedural grounds, but for reasons of substance as well. I believe that a prescription drug benefit under Medicare must adhere to three principles: the benefit must be universal, it must be comprehensive, and it must be affordable. The Republican proposal fails on all three times tests.

This bill lacks universality. I believe a Medicare prescription drug program should be available to eligible senior citizens or disabled persons from Michigan to Maine, from Oregon to Ohio, from Alaska to Alabama. This bill does not guarantee prescription drug coverage for all Medicare beneficiaries at an affordable price. It is restricted to only those who can afford to purchase private market drug plans.

The Republican plan lacks a comprehensive package of benefits. My Republican colleagues point out that their plan is not a ''one size fits all'' plan. That is a cliche without meaning. I would suggest it is important to define by what ''one size fits all'' means. If one size fits all means a comprehensive set of pharmaceutical products, then I am for it. If one size fits all means that new drugs become available to everyone then I am for it. If one size fit all means that the prescription drug program is responsive to the needs of our severely disabled, then I am for that, too. The Republican plan is far from comprehensive.

The Republican bill creates a multi-tiered system of coverage with the lowest beneficiaries limited to bargain basement plans. The Republican plan subsided private health insurance companies to offer ''Medigap-like'' policies providing prescription drug coverage to Medicare beneficiaries. Even the president of the Health Insurance Association of America (HIAA) has said that private insurance

companies will not offer these drug policies because they do not want to assume the financial risks.

Although the bill contains no set deductible or premium, it is guesstimated by members of the Ways and Means Committee that seniors will pay a $250 deductible and a monthly premium of $37 to $40—a total of $700 off the top of modest budget as the price of admission for the benefit. The only way to make an affordable prescription drug coverage for all beneficiaries is to establish a prescription drug benefit administered by the Medicare program—just like benefits under part A and part B of Medicare. We need only look at Medigap insurance premiums costs seniors are charged for prescription drug coverage. Depending on the state, drug coverage can be more than $100 per month for a person 65 years of age and more than $200 per month for a 75-year old. This plan for fails to meet the test of affordability.

Another glaring defect of the Republican plan is that the benefits are not guaranteed. Medicines may be limited by private plans, and pharmacies may also be limited. Private insurers could discourage seniors with high drug costs from enrolling by offering plans that have few up-front costs such as no deductible and low co-payments but leave seniors paying a large amount before the $6,000 catastrophic threshold kicks in. Under the GOP bill, Medicare would not provide a single dollar of direct premium assistance for middle-class beneficiaries whose income is above $12,000 a year. The bill subsidizes the insurers under theory that the private sector offer drug benefit coverage at significant cost savings. Given the meager subsidies, it is very likely that the premiums would still be too expensive for many seniors.

The Republican plan is all bread and no meat, a false promise to our senior citizens. The plan undermines the Medicare program by contracting out the program to private insurers who will repeat corporate subsidies and produce very little for the health security needs of the nation's seniors. What the Republicans are asking us to do today is ''buy a pig in a poke.'' Frankly, that's not good enough for us and it's not good enough for our senior citizens.

We live in a special time in our nation's history. We are experiencing recorded economic growth and generating budget surpluses that are without precedent. The President's Mid-Session Review reported that budget surpluses over the next 10 years will total $4.2 trillion, a $1.3 trillion increase from the 10-year surpluses estimated in the President's budget issued last February.

We have no modern day record to guide us through this period of economic prosperity. Even in era of record budget surpluses and economic growth, I recognize the importance of keeping a watchful eye on the bottom line. At the same time, we have the resources to fund a reasonable prescription drug benefit that is universal, comphrensive and affordable. The Republican plan fails.

I urge my colleagues to joint me in voting against this bill.

Mr. WATTS of Oklahoma. Mr. Speaker, today I rise in support of H.R. 4680, the Medicare Prescription Drug Act of 2000. The Medicare program provides significant health insurance coverage for 39 million aged and disabled beneficiaries. However, the program does not offer protection against the costs of most outpatient prescription drugs. This has created a critical need for a significant drug benefit.

However, the potential cost of adding prescription drug coverage has been the primary impediment to its implementation. In response to this, Republicans have unveiled a plan to strengthen Medicare and provide prescription drug coverage for all senior citizens and disabled Americans, including those in rural areas. It focuses on three key principles: coverage will be affordable for all, available for all and voluntary for all—regardless of income or location.

In Oklahoma and other parts of rural America, health care is a matter of access. The Republican plan offers protections for seniors in rural areas by guaranteeing availability of at least two drug plans in every area of the country and requires convenient access to pharmacies.

The Republican plan utilizes a public-private partnership to let seniors choose the right coverage from several competing prescription drug plans, or to keep their existing coverage. The plan also protects seniors from high out-of-pocket drug costs, without resorting to price-fixing or government price controls.

We want to give individuals the power to decide what is best for them and choose the prescription drug coverage that best meets their needs. Therefore, I urge my colleagues to vote in favor of the Medicare Prescription Drug Act.

Mrs. MALONEY of New York. Mr. Speaker, today I rise in opposition to the Republican prescription drug plan. I want to make very clear that the 2 plans are strikingly different.

As co-chair of the Women's Caucus I want to stress the importance prescription drug coverage to older women throughout the country.

The average income for a woman over the age of 65 is just $14,820. Thus the Republican Leadership's prescription drug plan, which has proposed only a 50 percent decrease in drug costs, is still unaffordable to most older women.

Additionally, the suggested prescription plan's catastrophic coverage is not initiated until the beneficiary's drug costs have reached $6,000. This obviously does not provide seniors with the safety net they deserve given their limited incomes.

Furthermore, prescription drugs are now the largest out-of-pocket health care expense for America's seniors. On average, America's seniors fill 18 prescriptions each year, and nationally, spending on prescription medications increases 15 percent annually.

But even more disturbing is the growing evidence that many of America's major drug companies are engaging in a deliberate pattern of price discrimination.

Many seniors, without drug coverage, are being forced to pay prices that are significantly higher than those charged to other customers, such as large HMOs.

I was so concerned about this problem that I had the staff of one of the committees I serve on work with my staff to study the problem of drug pricing in my own district. And what they found shocked me.

First, they discovered that seniors in Manhattan without prescription drug coverage—and that is about three-quarters of today's seniors—pay two and a half times as much for certain prescription drugs as other consumers, such as members of large HMOs.

The study looked at the five best-selling prescription drugs and found that, in each case, seniors in my district pay more than twice what other consumers pay.

In one instance—the cholesterol medication Zocor—seniors in my district pay four times what consumers in HMOs pay.

In addition, they took a look at the prices American seniors pay and compared them to the prices that seniors in Mexico and Canada pay. In some cases, they pay seven times what consumers in other countries pay.

The conclusions of both studies were clear: drug companies are gouging America's seniors only to increase their own profits.

No senior should ever have to choose between buying needed prescription drugs and putting food on the table, or heating their homes, or having a decent retirement.

But with what drug companies are charging these days, those are the choices many seniors face without prescription drug coverage.

Prescription drugs prolong the lives of thousands of women and men each year. Enough is enough. Congress needs to produce a prescription drug plan that actually help seniors. America's seniors deserve better than this.

Mr. DIXON. Mr. Speaker, today I had hoped to have the opportunity to vote to create an affordable, workable prescription drug benefit for Medicare beneficiaries. Unfortunately, I was not given that opportunity by the House leadership. The only bill before us—the Medicare Rx 2000 Act, H.R. 4680—will not offer seniors the kind of protection against rising drug costs that they deserve.

While both Republicans and Democrats may agree on the need for a Medicare drug benefit, we disagree about important details such as affordability and reliability. I am disappointed that the Republican leadership has chosen to prevent the Democrats from offering our prescription drug plan as an alternative to their own during today's debate. An issue as serious as the availability of prescription drugs for seniors requires an open debate that explores all competing proposals.

I support the Democratic plan, H.R. 4770, which would create a voluntary, affordable prescription drug benefit in Medicare. The plan features inexpensive premiums and catastrophic coverage for drug costs over $4,000 annually. This is the type of plan my constituents have been asking for.

The Republican plan, in contrast, invites private insurance companies to offer drug-only plans to Medicare beneficiaries. There is no guarantee that private insurers would even want to offer these types of plans or that they would be affordable. In fact, the Health Insurance Association of America has said that drug-only plans are unworkable. Under the Republican plan, premiums will vary and catastrophic coverage would not begin until an enrollee reached $6,000 in yearly costs.

I will vote against H.R. 4680 because it does not provide the guaranteed, affordable Medicare drug benefit that my constituents need. I urge my colleagues to vote against this ill-advised bill so we can work together to craft a bipartisan prescription drug proposal that truly works for America's seniors.

Mr. BUYER. Mr. Speaker, I rise in support of the measure to provide prescription drug coverage to our seniors and disabled with Medicare coverage.

When Republicans took control of Congress in 1995, Medicare was going broke. Because

of the bipartisan actions taken in 1997, the Medicare program was preserved. Now, we are in a financial position to enhance Medicare, by adding a prescription drug benefit.

Mr. Speaker, seniors should not have to choose between buying food and buying prescription medicines. This bill, H.R. 4680, will give Medicare beneficiaries access to prescription drug insurance plans that negotiate lower prices and comprehensive coverage, something many seniors now lack.

Fortunately, near two-thirds of seniors have access to prescription drug coverage, most of which is provided as a retiree benefit from a lifetime of working. Seniors who prefer the coverage they have now should not be forced into a government run plan. But this is exactly what the President and the Democrat plan would do. If the President's plan were enacted, between 50 percent to 75 percent of employers would drop their coverage . . . coverage that many seniors like.

This plan, H.R. 4680, guarantees seniors choice on the type of prescription drug coverage that best suits their needs. All seniors will have at least 2 plans to choose from. The measure provides incentives for plans to be offered in rural areas and requires access to a ''bricks and mortar'' pharmacy. As a member who represents a rural constituency, I am pleased that this bill takes special care to see to the needs of seniors in rural America.

It is the senior who will decide what elements in a plan make sense for their situation. The President gives seniors one option, one benefit . . . take it or leave it.

H.R. 4680 provides subsidies for low-income seniors, just like the President's plan, and its also provides assurance that no senior would have to go bankrupt in order to pay high drug costs, unlike the President's original proposal. It guarantees that above $6,000, no senior would pay a penny more out-of-pocket. This catastrophic drug coverage is an extremely important provision.

The Republican plan also begins structural reforms in Medicare. It creates an ombudsman to advocate on behalf of the beneficiary, and not the bureaucracy. The ombudsman would help beneficiaries navigate Medicare's requirements. It reforms Medicare rules regarding appeals to eliminate the endless waits for decisions.

Under the President's plan, the government would become the largest HMO . . . deciding what drugs you can receive, and when you can get it. Like Canada, the President's plan would result in rationing of drug treatments, more hospital stays, and a lower standard of health care of our seniors.

This is a bill that provides access to affordable prescription drugs with a choice of affordable plans to meet the beneficiary's needs. This coverage is delivered in a way to protect the doctor-patient relationship. It does not compromise seniors' access to modern miracle medicines and ensures that research and development into new and improved drugs can continue.

I urge all Members to support this much needed bill.

Mr. BLUMENAUER. Mr. Speaker, I am encouraged that Congress is finally working to provide relief to our nation's seniors; however, the bill under consideration today does not do enough to help them. The only bill the Republicans offer, H.R. 4680, relies too much on private insurers who have already expressed opposition to providing drug coverage and who have already failed to provide adequate health insurance for many areas of the country, particularly rural areas.

Prescription drugs are an increasingly vital part of health care and are the fastest growing component of health care expenditures. Spending on prescription drugs is expected to reach $112 billion this year alone. Seniors, only 13 percent of the total population, account for more than a third of the annual expenditure. The average senior uses 18 prescriptions a year, prescriptions essential to their quality of life.

The rising costs of pharmaceuticals combined with the increasing reliance on drugs for medical treatments have created a serious threat to the financial security of a vulnerable population, seniors on fixed incomes.

The alternative legislation supported by the Administration and Congressional Democrats would do more to alleviate some of the financial burden imposed by prescription medications. The substitute bill, which was, unfortunately, prohibited from consideration today, offers coverage through the Medicare program that uses the purchasing power of the federal government to guarantee affordable prescription drug prices. Our seniors are paying the highest prescription drug prices in the world, not just in comparison with Canada, Mexico and other countries, but also with comparable medications offered to animals in veterinary clinics. The Republican proposal offers no guarantees that seniors who are purchasing drug coverage are being offered the best possible price for their pharmaceuticals.

The debate today on perhaps the most important domestic issue of this Congress has been haphazard and rushed. Consequently, it is likely that even if passed, the Administration will veto H.R. 4680. However, I hope the debate today is the beginning of a truly bi-partisan conversation about how we can focus our efforts beyond election year politics to a proposal that makes a real difference for those who depend on prescription drugs for their quality of life.

Mr. ETHERIDGE. Mr. Speaker, I rise today to announce my opposition to H.R. 4680, the Medicare Rx 2000 Act. This plan will not guarantee affordable prescription medicine coverage for all seniors and it takes the first step towards privatizing Medicare, forcing seniors to deal with private insurance companies instead of having the choice of getting their prescriptions through Medicare. The Republican plan provides huge subsidies to insurance companies and does not provide any direct assistance to our nation's seniors. Even after large subsidies, there is no guarantee that affordable prescription medicine coverage will be offered in every region of the country. In fact, we have heard from several insurance companies that ''the concept of 'dug-only' private insurance simply would not work in practice.''

I strongly support providing our nation's seniors with a real prescription medicine benefit. However, any such plan must be a defined benefit that is administered under Medicare. It must be voluntary, affordable, and available to all seniors regardless of their income level. The benefit must ensure that copayments and premiums are uniform for all seniors in all areas of the country. Finally, any plan enacted by this Congress must include a cap on the cost to seniors in order to protect them from any unexpected catastrophic events.

Mr. Speaker, for too long our nation's seniors have been forced to choose between purchasing prescription medicines and putting food on their tables. Because of this, I rise in support of the Democratic substitute. This plan will provide seniors with a meaningful, affordable, and universal medicine benefit. Under this plan, there is no deductible, there is a low, affordable monthly premium of $25 for all seniors and half of seniors' costs will be covered by Medicare up to $2000. In addition, this legislation includes a catastrophic benefit that will cap seniors' costs at a maximum of $4000. Finally, Mr. Speaker, I rise in support of the Democratic substitute because it will provide much needed relief to rural and urban Medicare hospitals, nursing homes, home health agencies, rural HMOs, and others providers.

Our North Carolina values call on us to provide health care security and retirement security for our senior citizens. The Republican bill utterly fails to meet that test.

Mrs. MEEK of Florida. Mr. Speaker, the American people want and need affordable, voluntary and reliable Medicare prescription drug coverage for all seniors, not this poll-driven attempt to con them. I rise in strong opposition to both the Republican Leadership's bill and to the disgraceful Rule adopted for this bill, a Rule that deprives the Democrats of an opportunity to present their substitute, a substitute that would give America's seniors the option to obtain affordable, reliable prescription drug coverage through Medicare. The procedures adopted by the Republican leadership for consideration of this bill are a travesty. The American people deserve better.

H.R. 4680, the Medicare 2000 Rx Prescription Act, is a prescription for disaster. This bill won't work. It seeks to provide prescription drug coverage to Medicare beneficiaries, not through Medicare, but by creating ''drugs only'' insurance policies through private insurers. It does so even in the face of the continuing massive withdrawals from Medicare by the health insurance industry. If you live on more than $12,525 a year, the Republican plan would not pay one dime toward your premium, while the Democratic plan would provide a 50 percent subsidy for monthly premiums for all seniors.

The bill would pour money into the pocket of wealthy insurance companies even though the insurance companies themselves have called this ''private insurer'' approach unworkable. There is no reason to believe that any legitimate private insurers will step forward and offer this coverage to seniors. A prescription drug benefit surely can and should be offered through the existing regulatory structure, but the Republican leadership simply cannot overcome their longstanding history of hostility to Medicare.

Instead of creating a defined benefit plan that would cover all with the same comprehensive benefits, the Republican bill would create a multi-tiered system of coverage that would relegate low-income beneficiaries to bargain basement plans. Private insurers would be free to define different deductibles, co-payments and benefit limits in different parts of the country.

The Republican plan would provide whatever subsidy might be required to persuade two insurers to offer a prescription drug benefit, but provide no assurance whatsoever that the benefits offered would be comprehensive and affordable. Plans would come in and out

of communities frequently, perhaps even on a yearly basis, and seniors would be left to fend with the fear, confusion, and uncertainty that all too many of them already have experienced when their insurers carrier abandons coverage in their market.

To induce insurance companies to offer this coverage, participating companies would receive a 35 percent subsidy for their operating costs with no requirement that such payments be passed on to the beneficiaries. Reflecting their never-ending devotion to ''trickle-down'' economics, the Republican bill would end up subsidizing insurers, not seniors. Plans also would be able to create restrictive formularies that would maximize the insurer's profits at the expense of seniors by refusing payment for many drugs, even though a beneficiary's doctor had determined that a particular drug is medically necessary.

This is not the approach that we need. What seniors want and deserve is a simple, reliable, affordable prescription drug plan financed through Medicare with no deductibles, universal benefits, guaranteed access to needed drugs and local pharmacies, and guaranteed access to negotiated discounts in drug prices using the purchasing power of the Federal government. Under the Democratic plan, all drug costs would be covered once a senior incurred $4,000 in out-of-pocket drug costs. Simply put, the Democratic plan offers far better coverage than the Republican plan and at a lower cost.

Mr. Speaker, it's no coincidence that the Republican leadership bill came to the Ways and Means Committee for a markup within days of being introduced and that seniors, the disabled, low income and minority populations, most members of the Congress and other citizens did not receive a chance to testify on H.R. 4680 before that markup. Nor is it an accident that this bill is now being rushed to the floor for a vote. There's a simple explanation.

After years of resisting Democratic proposals for a prescription drug benefit, the Leadership's pollsters told them that they could not ignore the issue any longer. They would pay too heavy a price politically. So the challenge then became one of figuring out how to appear to be addressing the issue without involving Medicare; to portray concern for the desperate needs of seniors for prescription drug coverage.

H.R. 4680 is the product of that exercise. 148 pages intended to suggest concern, but fundamentally inadequate to create affordable and reliable voluntary prescription drug coverage. Mr. Speaker, the leadership may have labored mightily to produce this bill, but they brought forth a mouse! As Families USE put it: ''This plan relies on the insurance industry to provide policies they don't want to sell and consumers can't afford to buy. It's impossible to tell what consumers will get or whether it will even be available. This is a false promise to Medicare beneficiaries.''

Mr. Speaker, the nature and extent of a senior's prescription drug benefit should not depend upon the accident of where that senior is located. Beneficiaries should pay the same premium and get the same benefits no matter where they live, just like they do for other Medicare services like doctors' visits and surgery. Seniors should be covered for all drugs that their doctors say are medically necessary. They should not be at the mercy of the insurance company's drug formulary.

Our constituents deserve a benefit that they can count on and understand, a guaranteed and affordable benefit—not the confusion and uncertainty that the Republican leadership's plan will promote.

Medicare has been the cornerstone of health security for the elderly and the disabled for over 30 years. We should build on the existing Medicare program to create a reliable and affordable prescription drug benefit for all beneficiaries who wish to participate. Our constituents need real affordable, reliable voluntary prescription drug coverage, not just election year rhetoric. Reject this sham proposal, adopt a fair process for considering the prescription drug issue, and let's work to adopt the Democratic substitute.

Mr. COSTELLO. Mr. Speaker, I rise today in strong opposition to H.R. 4680. It is outrageous that the Republican leadership blocked all attempts for free and open debate. A vote on the Democratic substitute was ruled out of order. The leadership has stifled consideration of any plan other than their own. It is obvious they are catering to the insurance companies. The ones who stand to gain the most from this legislation are not the seniors that the Republicans would lead you to believe but the multi-million dollar drug companies that only stand to get wealthier as a result of this legislation.

The Republican leadership's prescription drug plan fails miserably to help our nation's seniors. The leadership should be ashamed to submit a plan that forces seniors to shop around for benefits when there is no guarantee that the insurance companies will continue to provide the benefit a year or two down the road, especially when the fees for such a plan can be raised to exorbitant rates.

A better solution is President Clinton's plan which provides guaranteed benefits through Medicare, allows seniors to keep their current prescription drug plan if they choose and provides 100 percent of prescription expenses for low-income seniors. I support the President's plan because the plan provides affordable, voluntary and reliable prescription coverage for all seniors.

Give our nation's seniors what they deserve, prescription drug coverage without all the strings. I urge my colleagues to oppose the Republican prescription drug plan.

Mr. BALLENGER. Mr. Speaker, I rise today in support of H.R. 4680, the Medicare Prescription Drug and Modernization Act, as introduced by Subcommittee Chairman BILL THOMAS and my good friend and colleague from North Carolina Representative RICHARD BURR. I encourage my colleagues on both sides of the aisle to support this legislation which provides senior citizens with a voluntary drug benefit, giving seniors the right of choice.

Seniors comprise 12 percent of the population in the U.S., but consume more than one-third of all prescription drugs. Leaving seniors without a drug benefit is not an option. The time has come to correct this shortfall in Medicare and implement a program that provides a Medicare drug benefit for seniors. H.R. 4680 is a cost effective way to provide this benefit through the efficiency of the private sector.

I believe H.R. 4680 provides the best approach by giving seniors the flexibility of choice. Unlike the Democrats proposed bill, H.R. 4680 greatly diminishes the power of the Health Care Financing Administration (HCFA). Our bill creates a new agency to oversee the prescription drug and Medicare+Choice programs. This is a huge improvement, as the new agency's mission would be to foster innovation and competition in Medicare and ensure coverage in rural areas.

Our new drug benefit would reduce prescription drug costs to seniors by giving them market-based bargaining power. A recent study by the Lewin group found that individuals enrolled in private insurance plans are getting 30 percent to 39 percent discounts on their prescription drugs through their plans' negotiations with pharmaceutical manufacturers. Yet today more than ⅓ of seniors have no prescription coverage and pay the highest price for their medication. H.R. 4680 enables seniors to enroll in prescription drug plans (or Medicare+Choice plans) that will negotiate lower prescription drug prices on their behalf.

And, last by certainly not least, the funding for this bill comes entirely from greater than anticipated savings from the 1997 Balanced Budget Act. Congressional Republicans have committed $40 billion (or about ⅓ of those unanticipated savings) to fund a better and stronger Medicare system. This is an investment which will pay large dividends in the immediate future.

Mr. Speaker, I urge my colleagues to support this common sense legislation that provides maximum coverage and optimum choice for seniors. Simply put, H.R. 4680 is affordable, available, and voluntary for all.

Mr. HOLT. Mr. Speaker, I rise in opposition to the weak and untested legislation we are considering and in support of real voluntary, reliable, affordable, Medicare prescription drug coverage for our seniors.

I strongly support the inclusion of prescription drug coverage under the Medicare plan. Unfortunately, the only bill being considered on the floor of Congress today is not a Medicare prescription drug plan—it's an untested, unreliable, proposal that gives money to private insurance companies instead of seniors. What's worse, it offers no real relief to those in central New Jersey who need it.

Today, more than at any time in our nation's history, prescription medications are helping Americans live longer, healthier lives. It is difficult, however, for many that lack good health care coverage to afford these products. Older Americans—the men and women that won World War II, built our nation, and raised our families—shouldn't be forced to choose between medicine and food. They shouldn't have to worry that an insurance company clerk is going to deny them lifesaving medicine to save a buck.

It is only common sense that Medicare include drugs as an integral part of health care in its benefits package. Medicare is a program that works. Seniors rely on it. All of us should be able to agree on that. We must work together in a bipartisan fashion to include drug coverage under Medicare.

There are too many questions about this hastily-written plan we are voting on today. Insurance companies say they have no interest in writing the prescription drug coverage policies that the bill calls for. In central New Jersey, just a handful of insurance companies dominate the market. In addition, seniors' experience with HMO insurance plans is not good. Service is often unreliable. Premiums have risen by more than 100 percent in some instances. Well . . . health care that you can't

count on is no health care at all. We need to do better than that.

There are several proposals being considered in Congress which are intended to help seniors pay for prescription drugs. While I have opposed policies that put government price controls on medicines, some of the other proposals being discussed are promising. We need to put the politics aside and have a serious discussion about how to help seniors. They deserve it. We must help seniors by passing a voluntary, affordable, reliable Medicare prescription drug benefit that helps seniors and allows us to continue to develop these lifesaving drugs.

The choice we are faced with today is an easy one. We can vote with insurance companies or with senior citizens. Mr. Speaker, I choose to side with the seniors.

Mr. HOBSON. Mr. Speaker: I rise in support, of the important legislation before us today that will help seniors in Ohio's 7th Congressional District with the high cost of prescription drugs.

I first want to acknowledge the efforts of Chairman BLILEY and Chairman THOMAS, as well as the efforts of Representative BURR, Representative GREENWOOD, and Representative MCCRERY. They've worked long hours, and they have written a very good bill that adds a sustainable, fair, and compassionate drug benefit that modernizes the Medicare program so seniors can afford the drugs they depend on to stay healthy.

Our bill puts in place a new benefit in Medicare that allows seniors to receive their prescription drugs through at least two choices—as opposed to the one-size-fits-some approach advocated by the President. It does so in a fair way that lets seniors in my district keep their existing coverage, and in a way that provides assistance to every senior in financial distress or with unusually high drug costs. And every senior will benefit from the power of group discounts that will reduce the out-of-pocket cost of prescription drugs.

One of the truly innovative things this bill does, and which is long overdue in the Medicare program, is to create a new Medicare Benefits Administration outside of the current bureaucracy that will be focused on seniors and their benefits first and foremost.

Let's compare that to the existing agency that runs Medicare and that would run the program proposed by the President.

Seniors and health care providers in my district are very familiar with HCFA, the Health Care Financing Administration which runs Medicare. They also—unfortunately—also are very familiar with the technical answers they can't understand, busy phone lines, a general level of unresponsiveness, and the endless delays at that agency.

You might think that Congress would have a little better luck. Sadly, that is not the case. I want to tell my colleagues today about a letter I sent this week to HCFA that demonstrates the importance of our plan entrusting the administration of a new prescription drug benefit to a new senior-focused agency rather than HCFA.

For example, in 1997, Congress included a simple and straight-forward provision in the Balanced Budget Act of 1997 that would allow seniors that depend on a wheelchair or a similar piece of medical equipment some flexibility in ''upgrading'' an old or deteriorating piece of equipment.

Today, three years after Congress enacted this improvement for seniors, seniors are still waiting for the current bureaucracy to act. The point is, three, four or five years is too long to make seniors wait. And the President's new claim that HCFA could implement a new prescription drug benefit in a year and a half flies in the face of their actual track record.

My colleagues can point to scores of missed deadlines on similar changes approved by Congress. We can't afford to take the same road with a prescription drug plan, and I believe our creation of a new Medicare Benefits Administration is a key improvement over the President's plan.

I also want to address the idea that a prescription drug benefit should follow the Canadian model. Some have advocated the solution is simple—seniors just need to import the drugs from Canada.

However, for those who support importing the Canadian system, let's take a look at prescription drugs in Canada. Since we last had this debate in 1994, Americans have not forgotten that the way Canada keeps costs down is simple—they don't provide the type of quality care we do in the United States, they allow the government instead of doctors make medical decisions, and health care is rationed—and the result is long waiting periods, where months or even years, for medical treatments are the norm.

With respect to drugs, in Canada, it takes an average of one and a half times as long as in the U.S. to approve a new drug. Since Canadians then can only take the drugs their government has approved payment for, they then have to wait even longer to learn if the government will allow that drug in their medicine cabinet.

In comparison, our bill provides the same type of discounts available under the socialist, state-run Canadian health care monopoly but instead relies on the power of the marketplace, group discounts, and competitive pricing to achieve these price reductions for seniors. Let's duplicate the cost savings, but let's not think again about importing a failed Canadian health care plan—which Americans overwhelmingly rejected the last time it was proposed.

Let me conclude by saying that it is time for Congress to act. I am deeply disappointed by reports in the media that opponents of our legislation don't want to support this bill so they can point their fingers and say that this is a ''do-nothing Congress.'' Enough already.

It's time to stop playing politics with this issue and pass this legislation to help the seniors in my Ohio district afford prescription drugs. I urge my colleagues to support the bill.

Mr. MCGOVERN. Mr. Speaker, I rise today in strong opposition to the sham of a prescription drug plan the Republican Majority has forced upon this Chamber. For the past few years, I have joined many members in attempting to create a guaranteed Medicare Prescription Drug Benefit. Today, we are voting on a poll-driven handout to the insurance companies, and not a defined benefit available to all seniors that want such a plan.

Mr. Speaker, the Democratic prescription drug plan, which the Majority is refusing to let us offer today, is a true Medicare benefit. Our plan is simple, common sense. We use the existing and successful Medicare program to administer a guaranteed benefit for every Medicare patient that wants to take part. Our plan has deductible, very low monthly premiums and a catastrophic benefit. The catastrophic benefit is the key part of our plan because thousands of seniors across this country are facing extremely high prescription drug bills that they have trouble paying. There is no reason that in this time of economic prosperity that America's seniors should have to choose between food and medicine. The Democratic bill will provide real relief for seniors so they do not have to make these life-threatening decisions.

The Republican plan is nothing more than a handout to the insurance companies. Their plan is a means-tested, private plan that would provide modest incentives for insurance companies to provide a deficient benefit to a limited number of seniors. But the irony is that the insurance companies have already rejected this handout. Insurance companies are in the business of making profits, and they are not going to enter a market where they cannot make a profit.

Instead of working to provide a comprehensive prescription benefit that every senior can have the option of joining, the Majority devised a poll-driven plant hat furthers their political goal of privatizing Medicare. They have never supported Medicare and have been waiting anxiously for, as former Speaker Gingrich said, Medicare to ''wither on the vine.''

Across my district, seniors consistently approach me, clutching their drug bills, and ask me how they can pay for their expensive bills on their fixed incomes. Unfortunately, there's no help for the seniors across America unless they have access to a Medicare HMO (which thousands of rural patients do not), have a private health insurance plan, or have a costly Medigap plan. The reality is that if Medicare were developed from scratch today, a prescription drug benefit would be one of the first provisions added to the program. We have a responsibility to provide seniors with a guaranteed prescription drug benefit.

Mr. Speaker, this debate today is an exercise in futility. The Majority is attempting to insulate itself from public opinion with a prescription drug plan that is hollow and provides no real relief for America's seniors. They are trying to pull a fast one on the American public. I urge my colleagues to reject this political grandstanding and to work for a real, guaranteed Medicare prescription drug benefit.

Mr. FRELINGHUYSEN. Mr. Speaker, I spent the last two Saturdays in the 11th Congressional District of New Jersey meeting with my constituents in town meetings as I have done on so many other weekends in the past. Through winter, spring and now summer, one of the issues I get asked about is: when will Congress provide a prescription drug benefit for our older Americans?

Our constituents should not have to choose between putting food on the table or paying for their next month's supply of medicine. Our older men and women want, and deserve, the peace of mind that comes with knowing they are covered by a safe, affordable, and easily accessible prescription drug benefit.

The tremendous advances in medical science have produced amazing medical breakthroughs that help older Americans live longer, healthier, more active and independent lives. And so much of this is due to the continued development of new and better medicines that keep people healthy and out of hospitals.

And while 65 percent of older men and women in America already have some form of

prescription medication coverage, there are still too many who do not. Congress, and the President, need to provide a prescription benefit that allows choice, is affordable, available to all, and one that our older Americans can depend on to provide safe, effective therapies now and for the future.

Today's action in the House is a good first step—and it's not the last step, either. But as we take this first step, and each one that will follow, we need to work together, Democrats and Republicans alike. Prescription medication coverage isn't a political issue; it's a health issue. Older Americans need us to work together to keep the Medicare program strong and solvent and to modernize the Medicare program to reflect today's health care needs. Unlike 30 years ago when Medicare was first designed, today medicines are an integral, important part of health care, and without such prescription drug coverage, medical coverage for our seniors is incomplete. So, let's work together and help give our older Americans the health care coverage they need and deserve.

Mr. PORTMAN. Mr. Speaker, when Medicare was created in 1965, prescription drugs were not used as they are today to treat health problems. That's all changed. Advances in pharmaceutical research and development have made it possible to address many complex health problems with a simple trip to the pharmacist.

Unfortunately, as more and more Americans have come to rely on prescription drugs, their costs have escalated, making it difficult for many seniors to make ends meet. Clearly, it is time to offer a prescription drug benefit to all seniors.

Today, about two-thirds of seniors have some kind of prescription drug coverage—either through a private plan they purchased or through a company retirement plan—that helps them to offset the cost of prescription drugs. But the remaining one-third of seniors have no coverage, and everyone feels the pinch of rising drug costs.

Under the plan before us today, Medicare would offer a voluntary prescription drug benefit that would be similar to private drug insurance that many seniors carry today. If you're eligible for Medicare, you'd be given a choice between at least two plans that offer prescription drug coverage. All you would have to do is to go to a local pharmacy to get your prescription filled, show them your Medicare prescription drug card, and pay a pre-determined co-payment. There would be no claims to file or forms to fill out.

To ensure that prescription drugs remain affordable, seniors who choose to enroll in such a Medicare prescription drug program would also be covered for so-called ''catastrophic'' prescription drug expenses. In other words, seniors would have the peace-of-mind to know that they will not be responsible for paying additional costs that might accrue if drug prices rise unexpectedly.

Because of the unprecedented purchasing power that a Medicare-wide prescription drug program will have, it will also help to lower drug prices for all Americans. A recent study concluded that, on average, there would be a 25% discount on the prescription drugs people need so badly. This will really help protect seniors from higher drug prices and rising out-of-pocket expenses. And, because this will be a voluntary program, it will help seniors who need it most while allowing seniors who currently have prescription drug coverage they like to continue to enjoy their existing plan.

Mr. Speaker, despite the heated rhetoric we're hearing on the floor today, Members on both sides of the aisle are very interested in adding a prescription drug benefit to Medicare. Yes, there are legitimate differences of opinion and approach. But we have a real opportunity to pass this bipartisan bill today—and to enact a Medicare prescription drug benefit this year.

I urge my colleagues on both sides of the aisle—let's do the right thing for America's seniors. Let's set aside the attack ads and the ''MediScare'' tactics—and provide Medicare prescription drug coverage for our constituents.

Mr. PASTOR. Mr. Speaker, with prescription drug expenses climbing ever higher, 75% of Medicare beneficiaries do not have dependable, comprehensive prescription drug coverage, and many American seniors are forced to decide between the purchase of medication and other necessities such as food or electricity. This situation is simply not acceptable in a nation as prosperous as ours.

Congress must take action to restore the dignity of American seniors and ease the growing burden on American families. The time has come for an affordable, voluntary, and reliable Medicare prescription coverage plan. The need has never been greater and public support has never been stronger.

I am deeply disappointed that the Republican leadership in Congress seems intent on squandering this opportunity for meaningful action by limiting floor consideration to a single Republican proposal which would do little to provide affordable drug coverage to seniors.

While American seniors need the opportunity to purchase affordable drug coverage no matter where they live, the Republican proposal guarantees opportunities only to the insurance and drug industries it would subsidize, with no guarantee of affordable plans for all seniors.

While American families want the peace of mind that comes from defined and dependable coverage, the Republicans have introduced a sham proposal that even the insurance companies it would rely on say will simply not work.

While Americans seek universal relief from bearing the full burden of devastating prescription drug expenses, regardless of their health or income, the Republicans offer only a divisive political ploy.

There is an alternative. The Democrats today have introduced a plan that offers the security, equity and universality of coverage that our seniors deserve. Rather than private, stand-alone drug coverage that is neither affordable or workable, the Democratic plan builds upon the strengths of the Medicare program, providing voluntary access to basic drug benefits to all Medicare beneficiaries, regardless of their income, health status, or where they live. It is a plan that will truly help the Arizonans I represent, and a plan that I am proud to co-sponsor.

I call on the Republican leadership to move beyond political maneuvering and allow for meaningful and comprehensive debate on this issue which affects all of our constituents. Seniors in my district, and across America, deserve the security of an affordable and defined Medicare drug benefit. It is time that Congress rise to the occasion, listen to what the American people are so clearly calling for, and make it happen.

Mr. CALVERT. Mr. Speaker, I rise in support of H.R. 4680, the Medicare Prescription 2000 Act. The bill is a fiscally sound way to help our seniors with a vital need. As co-chair of the bi-partisan Generic Drug Equity Caucus, I am encouraged by the bill's support for generic drug use.

Currently, generics fill over 40 percent of all prescriptions in the United States, and are extremely affordable at only 10 to 15 cents for every dollar spent on brand name drugs. The Congressional Budget Office reported in 1994 that generic drug competition results in a cost savings to consumers of 8 to 10 billion dollars annually.

Mr. Speaker, I urge my colleagues to vote for this sensible bill. I hope that we can include an even more explicit preference for the use of generic drugs when the bill is conferenced with the Senate. This is a good bill, it's right solution at a critical time. We all should vote aye.

Mr. DAVIS of Virginia. Mr. Speaker, I rise today in support of H.R. 4680, the Medicare Rx 2000 Act. I believe that this important piece of legislation is the best way to address the dire impact the run-away costs of prescription drugs are having on our nation's senior citizens and disabled Americans.

The Medicare program provides significant health insurance coverage for its 39 million aged and disabled beneficiaries. However, the program fails to offer protection against the costs of most outpatient prescription drugs. Even though 65% of beneficiaries have some private or public coverage for these costs, many do not have adequate supplemental coverage for their drug costs.

The absence of a significant drug benefit has concerned me and many of my colleagues for quite a long time. However, the potential cost of adding prescription drug coverage has been the primary impediment to its implementation. This year, Congress has made a serious commitment to providing prescription drugs for seniors by specifically setting aside $40 billion dollars of the budget surplus to create a prescription drug plan and to strengthen the Medicare program.

I commend the Speaker's Task Force on Prescription Drugs, which has worked diligently to create a voluntary prescription drug plan that is accessible, affordable, and will not encroach on seniors who are currently satisfied by their supplemental plan. This private-public sector approach to providing prescription drugs to every interested senior is modeled after the Federal Employees Health Benefit Program (FEHBP), which combines the advantages of a ''defined benefits'' plan and a ''defined contribution'' plan. To those who choose to participate in this plan, the premiums are affordable, averaging just $37 a month. And by allowing seniors to participate in an insurance-based plan at a reduced cost, it will give seniors the benefit of group bargaining power, which will reduce the price tag for prescription drugs. Studies show that Americans with insurance coverage pay 15 to 39 percent less for prescription drugs than those without insurance.

Most importantly, the Medicare Rx plan creates choices for seniors. H.R. 4680 will mandate that at least two prescription drug plans will be available in every area of the United States. A choice of plans will give Medicare beneficiaries the power to determine which high-quality private insurance plan would best

serve their individual healthcare needs. Having more than one plan in every district also spurs competition between plans, creating incentives for plans to create better products.

H.R. 4680 also reaches out to those individuals who are not financially able to afford their prescription medicine needs due to their income level or their escalating drug needs. This bill provides a full subsidy to low-income beneficiaries up to 135% of the poverty level and phases out that subsidy on a sliding scale to 150% of the poverty level. Furthermore, H.R. 4680 caps exorbitant drug costs with catastrophic drug coverage, meaning that Medicare will pay 100% of every seniors' drug costs beyond a certain level.

Mr. Speaker, seniors deserve access to the best medicines available to lead healthy and independent lives and, in many cases, to avoid more expensive treatments such as surgery or hospitalization. We need to expand seniors' access to the same kind of private-sector plans that millions of working Americans benefit from. I urge all my colleagues to vote in support of the Medicare Rx Act of 2000, a fair and responsible prescription drug plan for all of America's seniors.

The SPEAKER pro tempore (Mr. LAHOOD). All time for debate has expired.

Pursuant to House Resolution 539, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. STARK

Mr. STARK. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. STARK. I am, Mr. Speaker.

Mr. THOMAS. Mr. Speaker, I reserve all points of order against the motion.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. STARK moves to recommit the bill H.R. 4680 to the Committee on Ways and Means with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000''.

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Prescription medicine coverage was not a standard part of health insurance when the medicare program under title XVIII of the Social Security Act was enacted in 1965. Since 1965, however, medicine coverage has become a key component of most private and public health insurance coverage, except for the medicare program.

(2) At least ⅔ of medicare beneficiaries have unreliable, inadequate, or no medicine coverage at all.

(3) Seniors who do not have medicine coverage typically pay, at a minimum, 15 percent more than people with coverage.

(4) Medicare beneficiaries at all income levels lack prescription medicine coverage, with more than ½ of such beneficiaries having incomes greater than 150 percent of the poverty line.

(5) The number of private firms offering retiree health coverage is declining.

(6) Medigap premiums for medicines are too expensive for most beneficiaries and are highest for older senior citizens, who need prescription medicine coverage the most and typically have the lowest incomes.

(7) While the management of a medicare prescription medicine benefit program should mirror the practices employed by benefit administrators in delivering prescription medicines, the Secretary of Health and Human Services should oversee that program to assure that a guaranteed and defined prescription drug benefit is provided to all medicare beneficiaries.

(8) All medicare beneficiaries should have access to a voluntary, reliable, affordable, dependable, and defined outpatient medicine benefit as part of the medicare program that assists with the high cost of prescription medicines and protects them against excessive out-of-pocket costs.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT PROGRAM

SEC. 101. ESTABLISHMENT OF THE MEDICARE PRESCRIPTION MEDICINE BENEFIT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED

''ESTABLISHMENT OF DEFINED PRESCRIPTION MEDICINE BENEFIT PROGRAM FOR THE AGED AND DISABLED UNDER THE MEDICARE PROGRAM

''SEC. 1860. (a) IN GENERAL.—There is established as a part of the medicare program under this title a voluntary insurance program to provide defined prescription medicine benefits, including pharmacy services, in accordance with the provisions of this part for individuals who are aged or disabled or have end-stage renal disease and who voluntarily elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

''(b) NONINTERFERENCE BY THE SECRETARY.—In administering the prescription medicine benefit program established under this part, the Secretary may not—

''(1) require a particular formulary, institute a price structure for benefits, or in any way ration benefits;

''(2) interfere in any way with negotiations between benefit administrators and medicine manufacturers, or wholesalers; or

''(3) otherwise interfere with the competitive nature of providing a prescription medicine benefit using private benefit administrators, except as is required to guarantee coverage of the defined benefit.

''SCOPE OF DEFINED BENEFITS; COVERAGE OF ALL MEDICALLY NECESSARY PRESCRIPTION MEDICINES

''SEC. 1860A. (a) IN GENERAL.—The benefits provided to an individual enrolled in the insurance program under this part shall consist of—

''(1) payments made, in accordance with the provisions of this part, for covered prescription medicines (as specified in subsection (b)) dispensed by any pharmacy participating in the program under this part (and, in circumstances designated by the benefit administrator, by a nonparticipating pharmacy), including any specifically named medicine prescribed for the individual by a qualified health care professional regardless of whether the medicine is included in a formulary established by the benefit administrator if such medicine is certified as medically necessary by such health care professional (except that to the maximum extent possible the substitution and use of lower-cost generics shall be encouraged); and

''(2) charging by pharmacies of the negotiated discount price—

''(A) for all covered prescription medicines, without regard to such basic benefit limitation; and

''(B) established with respect to any drugs or classes of drugs described in subparagraphs (A), (B), (D), (E), or (F) of section 1927(d)(2) that are available to individuals receiving benefits under this title.

''(b) COVERED PRESCRIPTION MEDICINES.—

''(1) IN GENERAL.—Covered prescription medicines, for purposes of this part, include all prescription medicines (as defined in section 1860J(1)), including smoking cessation agents, except as otherwise provided in this subsection.

''(2) EXCLUSIONS FROM COVERAGE.—Covered prescription medicines shall not include drugs or classes of drugs described in subparagraphs (A) through (D) and (F) through (H) of section 1927(d)(2) unless—

''(A) specifically provided otherwise by the Secretary with respect to a drug in any of such classes; or

''(B) a drug in any of such classes is certified to be medically necessary by a health care professional.

''(3) NONDUPLICATION OF PRESCRIPTION MEDICINES COVERED UNDER PART A OR B.—A medicine prescribed for an individual that would otherwise be a covered prescription medicine under this part shall not be so considered to the extent that payment for such medicine is available under part A or B (including all injectable drugs and biologicals for which payment was made or should have been made by a carrier under section 1861(s)(2) (A) or (B) as of the date of enactment of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000). Medicines otherwise covered under part A or B shall be covered under this part to the extent that benefits under part A or B are exhausted.

''(4) STUDY ON INCLUSION OF HOME INFUSION THERAPY SERVICES.—Not later than one year after the date of the enactment of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000, the Secretary shall submit to Congress a legislative proposal for the delivery of home infusion therapy services under this title and for a system of payment for such a benefit that coordinates items and services furnished under part B and under this part.

''PAYMENT OF DEFINED BASIC AND CATASTROPHIC BENEFITS

''SEC. 1860B. (a) PAYMENT OF BENEFITS.—There shall be paid from the Prescription Medicine Insurance Account within the Supplementary Medical Insurance Trust Fund, in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription medicines in a calendar year, the sum of the benefit amounts under subsections (b) and (c).

''(b) BASIC BENEFIT.—

''(1) IN GENERAL.—An amount (not exceeding 50 percent of the annual limitation under paragraph (3)) equal to the applicable government percentage (specified in paragraph (2)) of the negotiated price for each such covered prescription medicine or such higher percentage as is proposed under section 1860G(d)(9).

''(2) APPLICABLE GOVERNMENT PERCENTAGE.—The applicable government percentage specified in this paragraph is 50 percent or such higher percentage as may be proposed under section 1860G(d)(9), if the Secretary finds that such higher percentage will not increase aggregate costs to the Prescription Medicine Insurance Account.

''(3) ANNUAL LIMITATION IN BASIC BENEFIT.—

''(A) FOR 2003 THROUGH 2009.—For purposes of the basic benefit described in paragraph (1), the annual limitation under this paragraph is—

''(i) $2,000 for each of 2003 and 2004;

''(ii) $3,000 for each of 2005 and 2006;

''(iii) $4,000 for each of 2007 and 2008; and

''(iv) $5,000 for 2009.

''(B) FOR 2010 AND SUBSEQUENT YEARS.—For purposes of paragraph (1), the annual limitation under this paragraph for 2010 and each subsequent year is equal to the limitation for the preceding year adjusted by the annual percentage increase in average per capita aggregate expenditures for covered outpatient medicines in the United States for medicare beneficiaries, as estimated by the Secretary. Any amount determined under this subparagraph that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(c) CATASTROPHIC BENEFIT.—

''(1) FOR 2003.—In the case of and with respect to out-of-pocket expenditures, the amount of such expenditures that exceeds the catastrophic benefit level established by the Secretary under paragraph (2) and increased in subsequent years by the annual percentage increase under paragraph (3).

''(2) ESTABLISHMENT OF CATASTROPHIC BENEFIT LEVEL.—The Chief Actuary shall estimate, over each five-year period, beginning with 2003, the amount of savings to the program under this title attributable to the operation of section 103 of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000. Based on such estimates, the Secretary shall establish the catastrophic benefit level in a manner so that the aggregate amount of expenditures under this paragraph does not exceed the aggregate amount of such savings, except that in 2003 and each year thereafter, the catastrophic benefit level may not be greater than $4,000, as adjusted under paragraph (3).

''(3) INDEXING FOR OUTYEARS.—For a year beginning after 2003, the catastrophic benefit level shall be increased by annual percentage increase determined for the year involved under subsection (b)(3)(B).

''ELIGIBILITY AND ENROLLMENT

''SEC. 1860C. (a) ELIGIBILITY.—Every individual who, in or after 2003, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll in the insurance program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by regulations.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section applied to this part, except as otherwise explicitly provided in this part.

''(2) SINGLE ENROLLMENT PERIOD.—Except as provided in section 1837(i) (as such section applies to this part), 1860E (relating to loss of coverage under the medicaid program), or 1860H(e) (relating to loss of employer or union coverage), or as otherwise explicitly provided, no individual shall be entitled to enroll in the program under this part at any time after the initial enrollment period without penalty, and in the case of all other late enrollments, the Secretary shall develop a late enrollment penalty for the individual that fully recovers the additional actuarial risk involved in providing coverage for the individual.

''(3) SPECIAL ENROLLMENT PERIOD IN 2003.—

''(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2003 may, at any time on or before December 31, 2003—

''(i) enroll in the program under this part; and

''(ii) enroll or reenroll in such program after having previously declined or terminated enrollment in such program.

''(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

''MONTHLY PREMIUM; INITIAL $25 PREMIUM

''SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF GUARANTEED SINGLE RATE FOR ALL PARTICIPATING BENEFICIARIES.—

''(1) $25 MONTHLY PREMIUM RATE IN 2003.—The monthly premium rate in 2003 for prescription medicine benefits under this part is $25.

''(2) PREMIUM RATES IN SUBSEQUENT YEARS.—

''(A) IN GENERAL.—The Secretary shall, during September of 2003 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this paragraph.

''(B) DETERMINATION OF ANNUAL BENEFIT COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits (but not including catastrophic benefits under section 1860B(c)) that will be payable from the Prescription Medicine Insurance Account for prescription medicines dispensed in such calendar year with respect to enrollees in the program under this part. In calculating such amount, the Secretary shall include an appropriate amount for a contingency margin.

''(C) DETERMINATION OF MONTHLY PREMIUM RATES.—

''(i) IN GENERAL.—The Secretary shall determine the monthly premium rate with respect to such enrollees for such succeeding year, which shall be 1/12 of the share specified in clause (ii) of the amount determined under subparagraph (B), divided by the total number of such enrollees, and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) ENROLLEE AND EMPLOYER PERCENTAGE SHARES.—The share specified in this clause, for purposes of clause (i), shall be—

''(I) one-half, in the case of premiums paid by an individual enrolled in the program under this part; and

''(II) two-thirds, in the case of premiums paid for such an individual by a former employer (as defined in section 1860H(f)(2)).

''(D) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under this paragraph.

''(b) PAYMENT OF PREMIUMS.—

''(1) GENERALLY THROUGH DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

''(A) IN GENERAL.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a), (b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

''(B) TRANSFERS OF DEDUCTION TO ACCOUNT.—The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Prescription Medicine Insurance Account from the appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

''(2) OTHERWISE THROUGH DIRECT PAYMENTS BY ENROLLEE TO SECRETARY.—

''(A) IN THE CASE OF INADEQUATE DEDUCTION.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

''(B) OTHER CASES.—An individual enrolled in the insurance program under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe.

''(C) DEPOSIT OF PREMIUMS IN ACCOUNT.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund.

''(c) CERTAIN LOW-INCOME INDIVIDUALS.—For rules concerning premiums for certain low-income individuals, see section 1860E.

''PRESCRIPTION MEDICINE INSURANCE ACCOUNT

''SEC. 1860F. (a) ESTABLISHMENT.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Medicine Insurance Account' (in this section referred to as the 'Account').

''(b) AMOUNTS IN ACCOUNT.—

''(1) IN GENERAL.—The Account shall consist of—

''(A) such amounts as may be deposited in, or appropriated to, such fund as provided in this part; and

''(B) such gifts and bequests as may be made as provided in section 201(i)(1).

''(2) SEPARATION OF FUNDS.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

''(c) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts, subject to appropriations, as the Secretary certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''ADMINISTRATION OF BENEFITS

''SEC. 1860G. (a) ADMINISTRATION.—

''(1) USE OF PRIVATE BENEFIT ADMINISTRATORS AS PROVIDED FOR UNDER PARTS A AND B.—The Secretary shall provide for administration of the benefits under this part through a contract with a private benefit administrator designated in accordance with subsection (c), for enrolled individuals residing in each service area designated pursuant to subsection (b) (other than such individuals enrolled in a Medicare+Choice program under part C), in accordance with the provisions of this section.

''(2) GUARANTEE OF PROGRAM ADMINISTRATION.—In the case of a service area in which no private benefit administrator has entered into a contract with the Secretary under paragraph (1) for the administration of this part, the Secretary shall seek to enter into a contract with a fiscal intermediary under part A (with a contract under section 1816) or a carrier under part B (with a contract under section 1842) to administer this part in that service area in accordance with the provisions of subsection (d). If the Secretary is unable to enter into such a contract for that service area, the Secretary shall provide for the administration of this part in that service area in accordance with the provisions of subsection (d) through another benefit administrator.

''(b) DESIGNATION OF GEOGRAPHIC SERVICE AREAS.—

''(1) IN GENERAL.—The Secretary shall divide the total geographic area served by the programs under this title into an appropriate number of service areas for purposes of administration of benefits under this part.

''(2) CONSIDERATIONS IN DETERMINING SERVICE AREAS.—In determining or adjusting the number and boundaries of service areas under this subsection, the Secretary shall seek to ensure that—

''(A) there is a reasonable level of competition among entities eligible to contract to administer the benefit program under this section for each area; and

''(B) the designation of areas is consistent with the goal of securing contracts under this section that use the volume purchasing power of enrollees to obtain the same or similar type of prescription medicine discounts as are afforded favored, large purchasers.

''(c) DESIGNATION OF BENEFIT ADMINISTRATOR.—

''(1) AWARD AND DURATION OF CONTRACT.—

''(A) COMPETITIVE AWARD.—Each contract for a service area shall be awarded competitively in accordance with section 5 of title 41, United States Code, for a period (subject to subparagraph (B)) of not less than 2 nor more than 5 years.

''(B) REVIEW.—A contract for a service area shall be subject to an evaluation after a year and termination for cause.

''(2) ELIGIBLE BENEFIT ADMINISTRATORS.—An entity shall not be eligible for consideration as a benefit administrator responsible for administering the prescription medicine benefit program under this part in a service area unless it meets at least the following criteria:

''(A) TYPE OF ENTITY.—The entity shall be capable of administering a prescription medicine benefit program, and may be a prescription medicine vendor, wholesale and retail pharmacy delivery system, health care provider or insurer, any other type of entity as the Secretary may specify, or a consortium of such entities.

''(B) PERFORMANCE CAPABILITY.—The entity shall have sufficient expertise, personnel, and resources to perform effectively the benefit administration functions for such area.

''(C) FINANCIAL INTEGRITY.—The entity and its officers, directors, agents, and managing employees shall have a satisfactory record of professional competence and professional and financial integrity, and the entity shall have adequate financial resources to perform services under the contract without risk of insolvency.

''(3) PROPOSAL REQUIREMENTS.—

''(A) IN GENERAL.—An entity's proposal for award or renewal of a contract under this section shall include such material and information as the Secretary may require.

''(B) SPECIFIC INFORMATION.—A proposal described in subparagraph (A) shall—

''(i) include a detailed description of—

''(I) the schedule of negotiated prices that will be charged to enrollees;

''(II) how the entity will deter medical errors that are related to prescription medicines; and

''(III) proposed contracts with local pharmacy providers designed to ensure access, including compensation for local pharmacists' services;

''(ii) be accompanied by such information as the Secretary may require on the entity's past performance; and

''(iii) disclose ownership and shared financial interests with other entities involved in the delivery of the benefit as proposed.

''(4) CRITERIA FOR COMPETITIVE SELECTION.—In awarding a contract competitively, the Secretary shall consider the comparative merits of each of the applications by eligible entities, as determined on the basis of the entities' past performance and other relevant factors, with respect to the following:

''(A) the estimated total cost of the contract, taking into consideration the entity's proposed fees and price and cost estimates, as evaluated and adjusted by the Secretary in accordance with the provisions of the Federal Acquisition Regulation concerning contracting by negotiation;

''(B) prior experience in administering a type of health insurance program;

''(C) effectiveness in containing costs through obtaining discounts from manufacturers, pricing incentives, utilization management, and drug utilization review;

''(D) the quality and efficiency of benefit management services with respect to such matters as claims processing and benefits coordination; record-keeping and reporting; maintenance of medical records confidentiality; and drug utilization review, patient information, customer satisfaction, and other activities supporting quality of care; and

''(E) such other factors as the Secretary deems necessary to evaluate the merits of each application.

''(5) FLEXIBILITY IN SECURING BEST BENEFIT ADMINISTRATOR.—In awarding contracts under this subsection, the Secretary may waive conflict of interest rules generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the purposes of the programs under this title and the best interests of enrolled individuals; and

''(B) will permit a sufficient level of competition for such contracts, promote efficiency of benefits administration, or otherwise serve the objectives of the program under this part.

If the Secretary waives such rules, the Secretary shall establish a special monitoring program to ensure that beneficiaries served by the benefit administrator have access to all necessary pharmaceuticals as prescribed.

''(6) MAXIMIZING COMPETITION AND SAVINGS.—In awarding contracts under this section, the Secretary shall give consideration to the need to maintain sufficient numbers of entities eligible and willing to administer benefits under this part to ensure vigorous competition for such contracts, while also giving consideration to the need for a benefit administrator to have sufficient purchasing power to obtain appropriate cost savings.

''(d) FUNCTIONS OF BENEFIT ADMINISTRATOR.—A benefit administrator for a service area shall (or in the case of the function described in paragraph (9), may) perform the following functions:

''(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

''(A) PRIVATELY NEGOTIATED PRICES.—Each benefit administrator shall establish, through negotiations with medicine manufacturers and wholesalers and pharmacies, a schedule of prices for covered prescription medicines.

''(B) AGREEMENTS WITH ANY WILLING PHARMACY.—Each benefit administrator shall enter into participation agreements under subsection (e) with any willing pharmacy, that include terms that—

''(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access);

''(ii) permit the participation of any willing pharmacy in the service area that meets the participation requirements described in subsection (e); and

''(iii) allow for reasonable dispensing and consultation fees for pharmacies.

''(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Each benefit administrator shall ensure that the negotiated prices established under subparagraph (A) and the list of pharmacies with agreements under subsection (e) are regularly updated and readily available in the service area to health care professionals authorized to prescribe medicines, participating pharmacies, and enrolled individuals.

''(2) TRACKING OF COVERED ENROLLED INDIVIDUALS.—In coordination with the Secretary, each benefit administrator shall maintain accurate, updated records of all enrolled individuals residing in the service area (other than individuals enrolled in a plan under part C).

''(3) PAYMENT AND COORDINATION OF BENEFITS.—

''(A) PAYMENT.—Each benefit administrator shall—

''(i) administer claims for payment of benefits under this part and encourage, to the maximum extent possible, use of electronic means for the submissions of claims;

''(ii) determine amounts of benefit payments to be made; and

''(iii) receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

''(B) COORDINATION.—Each benefit administrator shall coordinate with the Secretary, other benefit administrators, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of access to and payment for covered prescription medicines according to an individual's in-service area plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

''(C) EXPLANATION OF BENEFITS.—Each benefit administrator shall furnish to enrolled individuals an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription medicine benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(4) REQUIREMENTS WITH RESPECT TO FORMULARIES.—If a benefit administrator uses a formulary to contain costs under this part, the benefit administrator shall—

''(A) use a pharmacy and therapeutics committee comprised of licensed practicing physicians, pharmacists, and other health care practitioners to develop and manage the formulary;

''(B) include in the formulary at least 1 medicine from each therapeutic class and, if available, a generic equivalent thereof; and

''(C) disclose to current and prospective enrollees and to participating providers and pharmacies in the service area, the nature of the formulary restrictions, including information regarding the medicines included in the formulary and any difference in cost-sharing amounts.

''(5) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Each benefit administrator shall have in place effective cost and utilization management, drug utilization review, quality assurance measures, and systems to reduce medical errors, including at least the following, together with such additional measures as the Secretary may specify:

''(A) DRUG UTILIZATION REVIEW.—A drug utilization review program conforming to the standards provided in section 1927(g)(2) (with such modifications as the Secretary finds appropriate).

''(B) FRAUD AND ABUSE CONTROL.—Activities to control fraud, abuse, and waste, including prevention of diversion of pharmaceuticals to the illegal market.

''(C) MEDICATION THERAPY MANAGEMENT.—

''(i) IN GENERAL.—A program of medicine therapy management and medication administration that is designed to assure that covered outpatient medicines are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS OF MEDICATION THERAPY MANAGEMENT.—Such program may include—

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

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

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

''(iv) CONSIDERATIONS IN PHARMACY FEES.—The benefit administrators shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(6) EDUCATION AND INFORMATION ACTIVITIES.—Each benefit administrator shall have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription medicine benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

''(7) BENEFICIARY PROTECTIONS.—

''(A) CONFIDENTIALITY OF HEALTH INFORMATION.—Each benefit administrator shall have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Secretary may prescribe.

''(B) GRIEVANCE AND APPEAL PROCEDURES.—Each benefit administrator shall have in place such procedures as the Secretary may specify for hearing and resolving grievances and appeals, including expedited appeals, brought by enrolled individuals against the benefit administrator or a pharmacy concerning benefits under this part, which shall include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

''(8) RECORDS, REPORTS, AND AUDITS OF BENEFIT ADMINISTRATORS.—

''(A) RECORDS AND AUDITS.—Each benefit administrator shall maintain adequate records, and afford the Secretary access to such records (including for audit purposes).

''(B) REPORTS.—Each benefit administrator shall make such reports and submissions of financial and utilization data as the Secretary may require taking into account standard commercial practices.

''(9) PROPOSAL FOR ALTERNATIVE COINSURANCE AMOUNT.—

''(A) SUBMISSION.—Each benefit administrator may submit a proposal for decreased beneficiary cost-sharing for generic prescription medicines, prescription medicines on the benefit administrator's formulary, or prescription medicines obtained through mail order pharmacies.

''(B) CONTENTS.—The proposal submitted under subparagraph (A) shall contain evidence that such decreased cost-sharing would not result in an increase in aggregate costs to the Account, including an analysis of differences in projected drug utilization patterns by beneficiaries whose cost-sharing would be reduced under the proposal and those making the cost-sharing payments that would otherwise apply.

''(10) OTHER REQUIREMENTS.—Each benefit administrator shall meet such other requirements as the Secretary may specify.

''(e) PHARMACY PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with a benefit administrator to furnish covered prescription medicines and pharmacists' services to enrolled individuals residing in the service area.

''(2) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and requirements:

''(A) LICENSING.—The pharmacy and pharmacists shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

''(B) LIMITATION ON CHARGES.—Pharmacies participating under this part shall not charge an enrolled individual more than the negotiated price for an individual medicine as established under subsection (d)(1), regardless of whether such individual has attained the basic benefit limitation under section 1860B(b)(3), and shall not charge an enrolled individual more than the individual's share of the negotiated price as determined under the provisions of this part.

''(C) PERFORMANCE STANDARDS.—The pharmacy and the pharmacist shall comply with performance standards relating to—

''(i) measures for quality assurance, reduction of medical errors, and participation in the drug utilization review program described in subsection (d)(3)(A);

''(ii) systems to ensure compliance with the confidentiality standards applicable under subsection (d)(5)(A); and

''(iii) other requirements as the Secretary may impose to ensure integrity, efficiency, and the quality of the program.

''(D) DISCLOSURE OF PRICE OF GENERIC MEDICINE.—A pharmacy participating under this part that dispenses a prescription medicine to a medicare beneficiary enrolled under this part shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug that is therapeutically and pharmaceutically equivalent and bioequivalent.

''(f) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG BENEFIT ADMINISTRATORS.—During the period after the Secretary has given notice of intent to terminate a contract with a benefit administrator, the Secretary may transfer responsibilities of the benefit administrator under such contract to another benefit administrator.

''(g) GUARANTEED ACCESS TO MEDICINES IN RURAL AND HARD-TO-SERVE AREAS.—

''(1) IN GENERAL.—The Secretary shall ensure that all beneficiaries have guaranteed access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas, including through the use of incentives such as bonus payments to retail pharmacists in rural areas and extra payments to the benefit administrator for the cost of rapid delivery of pharmaceuticals, and any other actions necessary.

''(2) GAO REPORT.—Not later than 2 years after the implementation of this part the Comptroller General of the United States shall submit to Congress a report on the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in rural and hard-to-serve areas under this part together with any recommendations of the Comptroller General regarding any additional steps the Secretary may need to take to ensure the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in such areas under this part.

''(h) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary is authorized to include in a contract awarded under subsection (c) such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate, including—

''(1) bonus and penalty incentives to encourage administrative efficiency;

''(2) incentives under which benefit administrators share in any benefit savings achieved;

''(3) financial incentives under which savings derived from the substitution of generic medicines in lieu of non-generic medicines are made available to beneficiaries enrolled under this part, benefit administrators, pharmacies, and the Prescription Medicine Insurance Account; and

''(4) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization.

''INCENTIVE PROGRAM TO ENCOURAGE EMPLOYERS TO CONTINUE COVERAGE

''SEC. 1860H. (a) PROGRAM AUTHORITY.—The Secretary shall develop and implement a program under this section called the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription medicine benefits to retired individuals and to maintain such existing benefit programs, by subsidizing, in part, the cost of providing coverage under qualifying plans.

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

''(1) ASSURANCES.—The sponsor shall—

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

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

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

''(ii) immediately upon determining that the actuarial value of the prescription medicine benefit under the plan falls below the actuarial value of the insurance benefit under this part.

''(2) OTHER REQUIREMENTS.—The sponsor shall provide such information, and comply with such requirements, including information requirements to ensure the integrity of the program, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENT.—

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

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

''(B) was eligible for but was not enrolled in the insurance program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to ⅔ of the monthly premium amount payable from the Prescription Medicine Insurance Account for an enrolled individual, as set for the calendar year pursuant to section 1860D(a)(2).

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

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

''(e) PART D ENROLLMENT FOR INDIVIDUALS WHOSE EMPLOYMENT-BASED RETIREE HEALTH COVERAGE ENDS.—

''(1) ELIGIBLE INDIVIDUALS.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

''(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1860C(a);

''(B) at that time, the individual was covered under a qualified retiree prescription medicine plan for which an incentive payment was paid under this section; and

''(C)(i) the sponsor subsequently ceased to offer such plan; or

''(ii) the value of prescription medicine coverage under such plan became less than the value of the coverage under the program under this part.

''(2) SPECIAL ENROLLMENT PERIOD.—An individual described in paragraph (1) shall be eligible to enroll in the program under this part during the 6-month period beginning on the first day of the month in which—

''(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

''(B) the individual received notice of the change in benefits (in the circumstance described in paragraph (1)(C)(ii)).

''(f) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

''(3) QUALIFIED RETIREE PRESCRIPTION MEDICINE PLAN.—The term 'qualified retiree prescription medicine plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription medicines whose actuarial value to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

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

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

''APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS

''SEC. 1860I. (a) IN GENERAL.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Medicine Insurance Account, a Government contribution equal to—

''(1) the aggregate premiums payable for a month pursuant to section 1860D(a)(2) by individuals enrolled in the program under this part; plus

''(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers; plus

''(3) the benefits payable by reason of the application of section 1860B(c) (relating to catastrophic benefits).

''(b) APPROPRIATIONS TO COVER INCENTIVES FOR EMPLOYMENT-BASED RETIREE MEDICINE COVERAGE.—There are authorized to be appropriated to the Prescription Medicine Insurance Account from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under section 1860H(c).

''DEFINITIONS

''SEC. 1860J. As used in this part—

''(1) the term 'prescription medicine' means—

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

''(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin; and

''(2) the term 'benefit administrator' means an entity which is providing for the administration of benefits under this part pursuant to 1860G.''.

(b) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO FEDERAL SUPPLEMENTARY HEALTH INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking ''and'' after ''section 201(i)(1)''; and

(ii) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Medicine Insurance Account established by section 1860F'';

(B) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund),'';

(C) in the first sentence of subsection (h), by inserting before the period the following: ''and section 1860D(b)(4) (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund)''; and

(D) in the first sentence of subsection (i)—

(i) by striking ''and'' after ''section 1840(b)(1)''; and

(ii) by inserting before the period the following: '', section 1860D(b)(2) (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund)''.

(2) PRESCRIPTION MEDICINE OPTION UNDER MEDICARE+CHOICE PLANS.—

(A) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(i) in subsection (a)(1)(A), by striking ''parts A and B'' inserting ''parts A, B, and D''; and

(ii) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(B) VOLUNTARY BENEFICIARY ENROLLMENT FOR MEDICINE COVERAGE.—Section 1852(a)(1)(A) of such Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(C) ACCESS TO SERVICES.—Section 1852(d)(1) of such Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

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

''(F) the plan for prescription medicine benefits under part D guarantees coverage of any specifically named covered prescription medicine for an enrollee, when prescribed by a physician in accordance with the provisions of such part, regardless of whether such medicine would otherwise be covered under an applicable formulary or discount arrangement.''.

(D) PAYMENTS TO ORGANIZATIONS.—Section 1853(a)(1)(A) of such Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(i) by inserting ''determined separately for benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(ii) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(iii) by inserting before the last sentence the following: ''In the case of the payments for benefits under part D, such payment shall initially be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate. By 2006, the adjustments would be for the same risk factors applicable for benefits under parts A and B.''.

(E) CALCULATION OF ANNUAL MEDICARE +CHOICE CAPITATION RATES.—Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate'';

(ii) in paragraph (6)(A), by striking ''rate of growth in expenditures under this title'' and inserting ''rate of growth in expenditures for benefits available under parts A and B''; and

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

''(8) PAYMENT FOR PRESCRIPTION MEDICINES.—The Secretary shall determine a capitation rate for prescription medicines—

''(A) dispensed in 2003, which is based on the projected national per capita costs for prescription medicine benefits under part D and associated claims processing costs for beneficiaries under the original medicare fee-for-service program; and

''(B) dispensed in each subsequent year, which shall be equal to the rate for the previous year updated by the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for prescription medicines for an individual enrolled under part D.''.

(F) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of such Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PROVISION OF PART D BENEFITS.—In no event may a Medicare+Choice organization include as part of a plan for prescription medicine benefits under part D the following requirements:

''(A) NO DEDUCTIBLE; NO COINSURANCE GREATER THAN 50 PERCENT.—A requirement that an enrollee pay a deductible, or a coinsurance percentage that exceeds 50 percent.

''(B) MANDATORY INCLUSION OF CATASTROPHIC BENEFIT.—A requirement that the catastrophic benefit level under the plan be greater than such level established under section 1860B(c).''.

(G) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of such Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for benefits under parts A and B and for prescription medicine benefits under part D.''.

(H) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d) of such Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(6) AVAILABILITY OF NEGOTIATED PRICES.—Each contract under this section shall provide that enrollees who exhaust prescription medicine benefits under the plan will continue to have access to prescription medicines at negotiated prices equivalent to the total combined cost of such medicines to the plan and the enrollee prior to such exhaustion of benefits.''.

(3) EXCLUSIONS FROM COVERAGE.—

(A) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(B) PRESCRIPTION MEDICINES NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

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

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

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

''(J) in the case of prescription medicines covered under part D, which are not prescribed in accordance with such part;''.

SEC. 102. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION MEDICINE COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION TO BUY-IN DUALLY ELIGIBLE INDIVIDUALS.—

(1) COVERAGE OF PREMIUMS AS MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d) is amended in the second sentence of the flush matter at the end by striking ''premiums under part B'' the first place it appears and inserting ''premiums under parts B and D''.

(2) STATE COMMITMENT TO CONTINUE PARTICIPATION IN PART D AFTER BENEFIT LIMIT EXCEEDED.—Section 1902(a) of such Act (42 U.S.C. 1396a) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65)(B) and inserting ''; and''; and

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

''(66) provide that in the case of any individual whose eligibility for medical assistance is not limited to medicare or medicare medicine cost-sharing and for whom the State elects to pay premiums under part D of title XVIII pursuant to section 1860E, the State will purchase all prescription medicines for such individual in accordance with the provisions of such part D, without regard to whether the basic benefit limitation for such individual under section 1860B(b)(3) has been reached.''.

(b) GOVERNMENT PAYMENT OF MEDICARE MEDICINE COST-SHARING REQUIRED FOR QUALIFIED MEDICARE BENEFICIARIES.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

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

''(iii) premiums under section 1860D.''; and

(2) in subparagraph (D)—

(A) by inserting ''(i)'' after ''(D)''; and

(B) by adding at the end the following:

''(ii) PART D COST-SHARING.—The difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).''.

(c) GOVERNMENT PAYMENT OF MEDICARE MEDICINE COST-SHARING REQUIRED FOR MEDICARE BENEFICIARIES WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

(1) STATE PLAN REQUIREMENT.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end; and

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

''(v) for making medical assistance available for medicare medicine cost-sharing (as defined in section 1905(x)(2)) for qualified medicare medicine beneficiaries described in section 1905(x)(1); and''.

(2) 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE MEDICINE COST-SHARING.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

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

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

''(7) except in the case of amounts expended for an individual whose eligibility for medical assistance is not limited to medicare or medicare medicine cost-sharing, an amount equal to 100 percent of amounts as expended as medicare medicine cost-sharing for qualified medicare medicine beneficiaries (as defined in section 1905(x)); plus''.

(3) ADDITIONAL FUNDS FOR MEDICARE MEDICINE COST-SHARING IN TERRITORIES.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), by striking ''subsection (g),'' and inserting ''subsections (g) and (h)''; and

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

''(h) ADDITIONAL MEDICAID PAYMENTS TO TERRITORIES FOR MEDICARE MEDICINE COST-SHARING.—.

''(1) IN GENERAL.—In the case of a territory that develops and implements a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under subsection (f) (as increased under subsection (g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of some or all medicare medicine cost sharing (as defined in section 1905(x)(2)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in subsection (g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2003, is equal to $25,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860B(b)(3)(B) for the year involved.''.

(4) DEFINITIONS OF ELIGIBLE BENEFICIARIES AND COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(x)(1) The term 'qualified medicare medicine beneficiary' means an individual—

''(A) who is enrolled or enrolling under part D of title XVIII;

''(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as referred to in subsection (p)(2)) applicable to a family of the size involved; and

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

''(2) The term 'medicare medicine cost-sharing' means the following costs incurred with respect to a qualified medicare medicine beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

''(A) In the case of a qualified medicare medicine beneficiary whose income (as determined under paragraph (1)) is less than 135 percent of the official poverty line—

''(i) premiums under section 1860D; and

''(ii) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).

''(B) In the case of a qualified medicare medicine beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage of premiums under section 1860D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

''(3) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.''.

(d) MEDICAID MEDICINE PRICE REBATES UNAVAILABLE WITH RESPECT TO MEDICINES PURCHASED THROUGH MEDICARE BUY-IN.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) MEDICINES PURCHASED THROUGH MEDICARE BUY-IN.—The provisions of this section shall not apply to prescription medicines purchased under part D of title XVIII pursuant to an agreement with the Secretary under section 1860E (including any medicines so purchased after the limit under section 1860B(b)(3) has been exceeded).''.

(e) AMENDMENTS TO MEDICARE PART D.—Part D of title XVIII of the Social Security Act (as added by section 2) is amended by inserting after section 1860D the following new section:

''SPECIAL ELIGIBILITY, ENROLLMENT, AND COPAYMENT RULES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860E. (a) STATE OPTIONS FOR COVERAGE: CONTINUATION OF MEDICAID COVERAGE OR ENROLLMENT UNDER THIS PART.—

''(1) IN GENERAL.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual has previously declined the opportunity to enroll in such program.

''(2) ELIGIBILITY GROUPS.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1860C(a) and who are—

''(A) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

''(B) qualified medicare medicine beneficiaries (as defined in section 1905(x)(1)).

''(3) COVERAGE PERIOD.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

''(A) INDIVIDUALS ELIGIBLE (AT STATE OPTION) FOR PART B BUY-IN.—In the case of an individual described in subsection (a)(2)(A), the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

''(B) QUALIFIED MEDICARE MEDICINE BENEFICIARIES.—In the case of an individual described in subsection (a)(2)(B)—

''(i) the coverage period shall begin on the latest of—

''(I) January 1, 2003;

''(II) the first day of the third month following the month in which the State agreement is entered into; or

''(III) the first day of the first month following the month in which the individual satisfies section 1860C(a); and

''(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare medicine cost-sharing.

''(4) ENROLLMENT FOR LOW-INCOME SUBSIDY THROUGH OTHER MEANS.—

''(A) FLEXIBILITY IN ENROLLMENT PROCESS.—With respect to low-income individuals residing in a State enrolling under this part on or after January 1, 2003, the Secretary shall provide for determinations of whether the individual is eligible for a subsidy and the amount of such individual's income to be

made under arrangements with appropriate entities other than State medicaid agencies.

''(B) USE OF CERTAIN INFORMATION.—Arrangements with entities under subparagraph (A) shall provide for —

''(i) the use of existing Federal government databases to identify eligibility; and

''(ii) the use of information obtained under section 154 of the Social Security Act Amendments of 1994 for newly eligible medicare beneficiaries, and the application of such information with respect to other medicare beneficiaries.

''(b) SPECIAL PART D ENROLLMENT OPPORTUNITY FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In the case of an individual who—

''(1) satisfies section 1860C(a); and

''(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled under such plan or having been determined eligible for such benefits;

the Secretary shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'State' has the meaning given such term under section 1101(a) for purposes of title XIX.''.

(f) REMOVAL OF SUNSET DATE FOR COST-SHARING IN MEDICARE PART B PREMIUMS FOR CERTAIN QUALIFYING INDIVIDUALS.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv))is amended to read as follows—

''(iv) subject to section 1905(p)(4), for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

(2) RELOCATION OF PROVISION REQUIRING 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR CERTAIN QUALIFYING INDIVIDUALS.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by subsection (c)(3), is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) an amount equal to 100 percent of amounts expended as medicare cost-sharing described in section 1903(a)(10)(E)(iv) for individuals described in such section; plus''.

(3) REPEAL OF SECTION 1933.—Section 1933 is repealed.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2003.

SEC. 103. OFFSET FOR CATASTROPHIC PRESCRIPTION MEDICINE BENEFIT.

If the mid-summer 2000 budget estimate prepared by the Director of the Congressional Budget Office results in a higher level of projected on-budget surplus over the ten fiscal year period beginning with fiscal year 2001 than the projected on-budget surplus in the estimate prepared by the Director in March, 2000, there shall be transferred out of any moneys in the Treasury not otherwise appropriated in a fiscal year (beginning with fiscal year 2003) to the Prescription Medicine Insurance Account (created in the Federal Supplemental Medical Insurance Trust Fund established by section 1841 of the Social Security Act (42 U.S.C. 1395t)) such sums as are necessary to offset the costs attributable to the operation of section 1860B(a)(2) of the Social Security Act (as added by section 3) (relating to catastrophic benefit payment amounts) in that fiscal year.

SEC. 104. GAO ONGOING STUDIES AND REPORTS ON PROGRAM; MISCELLANEOUS REPORTS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the prescription medicine benefit program under part D of the Medicare program under title XVIII of the Social Security Act (as added by section 3 of this Act), including an analysis of each of the following:

(1) The extent to which the administering entities have –achieved volume-based discounts similar to the favored –price paid by other large purchasers.

(2) Whether access to the benefits under such program are in fact available to all beneficiaries, with special attention given to access for beneficiaries living in rural and hard-to-serve areas.

(3) The success of such program in reducing medication error and adverse medicine reactions and improving quality of care, and whether it is probable that the program has resulted in savings through reduced hospitalizations and morbidity due to medication errors and adverse medicine reactions.

(4) Whether patient medical record confidentiality is being maintained and safeguarded.

(5) Such other issues as the Comptroller General may consider.

(b) REPORTS.—The Comptroller General shall issue such reports on the results of the ongoing study described in (a) as the Comptroller General shall deem appropriate and shall notify Congress on a timely basis of significant problems in the operation of the part D prescription medicine program and the need for legislative adjustments and improvements.

(c) MISCELLANEOUS STUDIES AND REPORTS.—

(1) STUDY ON METHODS TO ENCOURAGE ADDITIONAL RESEARCH ON BREAKTHROUGH PHARMACEUTICALS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall seek the advice of the Secretary of the Treasury on possible tax and trade law changes to encourage increased original research on new pharmaceutical breakthrough products designed to address disease and illness.

(B) REPORT.—Not later than January 1, 2003, the Secretary shall submit to Congress a report on such study. The report shall include recommended methods to encourage the pharmaceutical industry to devote more resources to research and development of new covered products than it devotes to overhead expenses.

(2) STUDY ON PHARMACEUTICAL SALES PRACTICES AND IMPACT ON COSTS AND QUALITY OF CARE.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study on the methods used by the pharmaceutical industry to advertise and sell to consumers and educate and sell to providers.

(B) REPORT.—Not later than January 1, 2003, the Secretary shall submit to Congress a report on such study. The report shall include the estimated direct and indirect costs of the sales methods used, the quality of the information conveyed, and whether such sales efforts leads (or could lead) to inappropriate prescribing. Such report may include legislative and regulatory recommendations to encourage more appropriate education and prescribing practices.

(3) STUDY ON COST OF PHARMACEUTICAL RESEARCH.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study on the costs of, and needs for, the pharmaceutical research and the role that the taxpayer provides in encouraging such research.

(B) REPORT.—Not later than January 1, 2003, the Secretary shall submit to Congress a report on such study. The report shall include a description of the full-range of taxpayer-assisted programs impacting pharmaceutical research, including tax, trade, government research, and regulatory assistance. The report may also include legislative and regulatory recommendations that are designed to ensure that the taxpayer's investment in pharmaceutical research results in the availability of pharmaceuticals at reasonable prices.

(4) REPORT ON PHARMACEUTICAL PRICES IN MAJOR FOREIGN NATIONS.—Not later than January 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report on the retail price of major pharmaceutical products in various developed nations, compared to prices for the same or similar products in the United States. The report shall include a description of the principal reasons for any price differences that may exist.

TITLE II—IMPROVEMENT IN BENEFICIARY SERVICES

Subtitle A—Improvement of Medicare Coverage and Appeals Process

SEC. 201. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended to read as follows:

''DETERMINATIONS; APPEALS

''SEC. 1869. (a) INITIAL DETERMINATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

''(1) The initial determination of whether an individual is entitled to benefits under such parts.

''(2) The initial determination of the amount of benefits available to the individual under such parts.

''(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

''(b) APPEAL RIGHTS.—

''(1) IN GENERAL.—

''(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

''(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

''(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services

or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

''(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

''(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

''(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

''(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

''(D) TIME LIMITS FOR APPEALS.—

''(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described subparagraph (A) files notice with the Secretary to request reconsideration by not later than 180 days after the individual receives notice of the initial determination under subsection (a) or within such additional time as the Secretary may allow.

''(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

''(E) AMOUNTS IN CONTROVERSY.—

''(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

''(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow 2 or more appeals to be aggregated if the appeals involve—

''(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

''(II) common issues of law and fact arising from services furnished to 2 or more individuals by one or more providers of services or suppliers.

''(F) EXPEDITED PROCEEDINGS.—

''(i) EXPEDITED DETERMINATION.—In the case of an individual who—

''(I) has received notice by a provider of services that the provider of services plans to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

''(II) has received notice by a provider of services that the provider of services plans to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

''(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

''(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

''(2) REVIEW OF COVERAGE DETERMINATIONS.—

''(A) NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

''(I) Such a determination shall not be reviewed by any administrative law judge.

''(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

''(III) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(IV) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(ii) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Secretary respecting whether or not a particular item or service is covered nationally under this title, including such a determination under 1862(a)(1).

''(B) LOCAL COVERAGE DETERMINATION.—In the case of a local coverage determination made by a fiscal intermediary or a carrier under part A or part B respecting whether a particular type or class of items or services is covered under such parts, the following limitations apply:

''(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(ii) Such a determination may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(C) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of review of a determination under subparagraph (A)(i)(III) or (B)(i) where the moving party alleges that there are no material issues of fact in dispute, and alleges that the only issue is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction.

''(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

''(I) Issue a national coverage determination, with or without limitations.

''(II) Issue a national noncoverage determination.

''(III) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

''(IV) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

''(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

''(iii) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

''(E) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations.

''(ii) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

''(3) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

''(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

''(5) STANDING.—An action under this section seeking review of a coverage determination (with respect to items and services under this title) may be initiated only by one (or more) of the following aggrieved persons, or classes of persons:

''(A) Individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

''(B) Persons, or classes of persons, who make, manufacture, offer, supply, make available, or provide such items and services.

''(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under paragraphs (2) and (3) of subsection (a). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

''(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term 'qualified independent contractor' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a), and that meets the requirements established by the Secretary consistent with paragraph (3).

''(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the following requirements:

''(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required under regulations of the Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

''(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

''(i) such payment is allowed by reason of section 1879;

''(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

''(iii) such determination is changed as the result of any hearing by the Secretary or judicial review of the decision under this section; or

''(iv) such payment is authorized under section 1861(v)(1)(G).

''(C) DEADLINES FOR DECISIONS.—

''(i) DETERMINATIONS.—The qualified independent contractor shall conduct and conclude a determination under subparagraph (B) or an appeal of an initial determination, and mail the notice of the decision by not later than the end of the 45-day period beginning on the date a request for reconsideration has been timely filed.

''(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i), the party requesting the reconsideration or appeal may request a hearing before an administrative law judge, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

''(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or in accordance with the following:

''(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j), not later than 1 day after the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

''(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

''(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

''(i) PHYSICIANS.—No physician under the employ of a qualified independent contractor may review—

''(I) determinations regarding health care services furnished to a patient if the physician was directly responsible for furnishing such services; or

''(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the physician's family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

''(ii) PHYSICIAN'S FAMILY DESCRIBED.—For purposes of this paragraph, a physician's family includes the physician's spouse (other than a spouse who is legally separated from the physician under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents.

''(E) EXPLANATION OF DETERMINATIONS.—Any determination of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the determination as well as a discussion of the pertinent facts and applicable regulations applied in making such determination.

''(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

''(G) DISSEMINATION OF INFORMATION.—Each qualified independent contractor shall, using the methodology established by the Secretary under subsection (d)(4), make available all determinations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, and other entities under contract with the Secretary to make initial determinations under part A or part B or title XI.

''(H) ENSURING CONSISTENCY IN DETERMINATIONS.—Each qualified independent contractor shall monitor its determinations to ensure the consistency of its determinations with respect to requests for reconsideration of similar or related matters.

''(I) DATA COLLECTION.—

''(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

''(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

''(I) Specific claims that give rise to appeals.

''(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

''(III) Situations suggesting the need for changes in national or local coverage policy.

''(IV) Situations suggesting the need for changes in local medical review policies.

''(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

''(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the Secretary for a hearing, including as necessary, explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

''(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

''(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

''(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

''(A) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall promulgate regulations governing the processes of reconsiderations of determinations by the Secretary and qualified independent contractors and of hearings by the Secretary. Such regulations shall include such specific criteria and provide such guidance as required to ensure the adequate functioning of the reconsiderations and hearings processes and to ensure consistency in such processes.

''(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

''(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

''(II) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

''(II) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subclause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

''(ii) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (B) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

''(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

''(iv) DAB HEARING PROCEDURE.—In the case of a request described in clause (iii), the Departmental Appeals Board shall review the case de novo.

''(C) POLICIES.—The Secretary shall provide such specific criteria and guidance, including all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

''(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

''(E) EFFECT OF FAILURE TO PUBLISH POLICIES.—

''(i) NATIONAL AND LOCAL COVERAGE POLICIES.—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

''(ii) OTHER POLICIES.—With respect to policies established by the Secretary other than the policies described in clause (i), qualified independent contractors shall not be bound by such policies if the Secretary does not furnish to the qualified independent contractor the policies in a published format consistent with subparagraph (C).

''(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—

''(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

''(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and, in consultation with the Commissioner of Social Security, administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight may not be delegated to regional offices of the Department.

''(4) DISSEMINATION OF DETERMINATIONS.—The Secretary shall establish a methodology under which qualified independent contractors shall carry out subsection (c)(3)(G).

''(5) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

''(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.''.

(b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO MEDICARE+CHOICE INDEPENDENT APPEALS CONTRACTORS.—Section 1852(g)(4) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at the end the following: ''The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.''.

(c) CONFORMING AMENDMENT TO REVIEW BY THE PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g)) is amended by adding at the end the following new paragraph:

''(3) Findings described in paragraph (1) and determinations and other decisions described in paragraph (2) may be reviewed or appealed under section 1869.''.

SEC. 202. PROVISIONS WITH RESPECT TO LIMITATIONS ON LIABILITY OF BENEFICIARIES.

(a) EXPANSION OF LIMITATION OF LIABILITY PROTECTION FOR BENEFICIARIES WITH RESPECT TO MEDICARE CLAIMS NOT PAID OR PAID INCORRECTLY.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsections:

''(i) Notwithstanding any other provision of this Act, an individual who is entitled to benefits under this title and is furnished a service or item is not liable for repayment to the Secretary of amounts with respect to such benefits—

''(1) subject to paragraph (2), in the case of a claim for such item or service that is incorrectly paid by the Secretary; and

''(2) in the case of payments made to the individual by the Secretary with respect to any claim under paragraph (1), the individual shall be liable for repayment of such amount only up to the amount of payment received by the individual from the Secretary.

''(j)(1) An individual who is entitled to benefits under this title and is furnished a service or item is not liable for payment of amounts with respect to such benefits in the following cases:

''(A) In the case of a benefit for which an initial determination has not been made by the Secretary under subsection (a) whether payment may be made under this title for such benefit.

''(B) In the case of a claim for such item or service that is—

''(i) improperly submitted by the provider of services or supplier; or

''(ii) rejected by an entity under contract with the Secretary to review or pay claims for services and items furnished under this title, including an entity under contract with the Secretary under section 1857.

''(2) The limitation on liability under paragraph (1) shall not apply if the individual signs a waiver provided by the Secretary under subsection (l) of protections under this paragraph, except that any such waiver shall not apply in the case of a denial of a claim for noncompliance with applicable regulations or procedures under this title or title XI.

''(k) An individual who is entitled to benefits under this title and is furnished services by a provider of services is not liable for payment of amounts with respect to such services prior to noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), unless the following conditions are met:

''(1) The provider of services shall furnish a notice of discharge and appeal rights established by the Secretary under subsection (l) to each individual entitled to benefits under this title to whom such provider of services furnishes services, upon admission of the individual to the provider of services and upon notice of determination to discharge the individual from the provider of services, of the individual's limitations of liability under this section and rights of appeal under section 1869.

''(2) If the individual, prior to discharge from the provider of services, appeals the determination to discharge under section 1869 not later than noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), the provider of services shall, by the close of business of such first working day, provide to the Secretary (or qualified independent contractor under section 1869, as determined by the Secretary) the records required to review the determination.

''(l) The Secretary shall develop appropriate standard forms for individuals entitled to benefits under this title to waive limitation of liability protections under subsection (j) and to receive notice of discharge and appeal rights under subsection (k). The forms developed by the Secretary under this subsection shall clearly and in plain language inform such individuals of their limitations on liability, their rights under section 1869(a) to obtain an initial determination by the Secretary of whether payment may be made under part A or part B for such benefit, and their rights of appeal under section 1869(b), and shall inform such individuals that they may obtain further information or file an appeal of the determination by use of the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) maintained by the Secretary. The forms developed by the Secretary under this subsection shall be the only manner in which such individuals may waive such protections under this title or title XI.

''(m) An individual who is entitled to benefits under this title and is furnished an item or service is not liable for payment of cost sharing amounts of more than $50 with respect to such benefits unless the individual has been informed in advance of being furnished the item or service of the estimated amount of the cost sharing for the item or service using a standard form established by the Secretary.''.

(2) CONFORMING AMENDMENT.—Section 1870(a) of the Social Security Act (42 U.S.C. 1395gg(a)) is amended by striking ''Any payment under this title'' and inserting ''Except as provided in section 1879(i), any payment under this title''.

(b) INCLUSION OF BENEFICIARY LIABILITY INFORMATION IN EXPLANATION OF MEDICARE BENEFITS.—Section 1806(a) of the Social Security Act (42 U.S.C. 1395b–7(a)) is amended—

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

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) lists with respect to each item or service furnished the amount of the individual's liability for payment;'';

(4) in paragraph (3), as so redesignated, by striking the period at the end and inserting ''; and''; and

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

''(4) includes the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) for information and questions concerning the statement, liability of the individual for payment, and appeal rights.''.

SEC. 203. WAIVERS OF LIABILITY FOR COST SHARING AMOUNTS.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amended by striking clauses (i) through (iii) and inserting the following:

''(i) the waiver is offered as a part of a supplemental insurance policy or retiree health plan;

''(ii) the waiver is not offered as part of any advertisement or solicitation, other than in conjunction with a policy or plan described in clause (i);

''(iii) the person waives the coinsurance and deductible amount after the beneficiary informs the person that payment of the coinsurance or deductible amount would pose a financial hardship for the individual; or

''(iv) the person determines that the coinsurance and deductible amount would not justify the costs of collection.''.

(b) CONFORMING AMENDMENT.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) In this section, the term 'remuneration' includes the meaning given such term in section 1128A(i)(6).''.

Subtitle B—Establishment of Medicare Ombudsman

SEC. 211. Establishment of Medicare Ombudsman for Beneficiary Assistance and Advocacy.

(a) IN GENERAL.—Within the Health Care Financing Administration of the Department of Health and Human Services, there shall be a Medicare Ombudsman, appointed by the Secretary of Health and Human Services from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subsection (b).

(b) DUTIES.—The Medicare Ombudsman shall—

(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, a benefit administrator responsible for administering the prescription medicine benefit program under part D of title XVIII of the Social Security Act, or the Secretary;

(B) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C of title XVIII of such Act or a benefit administrator responsible for administering such prescription medicine benefit program; and

(C) submit annual reports to Congress and the Secretary, and include in such reports recommendations for improvement in the administration of this title as the Medicare Ombudsman determines appropriate.

(c) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

(1) provide information about the medicare program; and

(2) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

(d) DEFINITIONS.—In this section:

(1) The term ''medicare beneficiary'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both.

(2) The term ''medicare program'' means the insurance program established under title XVIII of the Social Security Act.

(3) The term ''fiscal intermediary'' has the meaning given such term under section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a)).

(4) The term ''carrier'' has the meaning given such term under section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f)).

(5) The term ''Medicare+Choice organization'' has the meaning given such term under section 1859(a)(1) of the Social Security Act (42 U.S.C. 1395w–29(a)(1)).

(6) The term ''Secretary'' means the Secretary of Health and Human Services.

TITLE III—MEDICARE+CHOICE REFORMS; PRESERVATION OF MEDICARE PART B DRUG BENEFIT

Subtitle A—Medicare+Choice Reforms

SEC. 301. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0 percentage points''.

SEC. 302. PERMANENTLY REMOVING APPLICATION OF BUDGET NEUTRALITY BEGINNING IN 2002.

Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), in the matter following clause (ii), by inserting ''(for years before 2002)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(before 2002)'' after ''for each year''.

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853(c)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is amended—

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

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

''(II) For 2002 for any of the 50 States and the District of Columbia, $450.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to years beginning with 2002.

SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

(a) IN GENERAL.—Section 1853(c)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking ''(ii) For a subsequent year'' and inserting ''(ii)(I) Subject to subclause (II), for a subsequent year''; and

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

''(II) During 2002, 2003, 2004, and 2005, in the case of a Medicare+Choice payment area in which there is no more than 1 contract entered into under this part as of July 1 before the beginning of the year, 102.5 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(b) CONSTRUCTION.—The amendments made by subsection (a) do not affect the payment of a first time bonus under section 1853(i) of the Social Security Act (42 U.S.C. 1395w–23(i)).

SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN CERTAIN MEDICARE+CHOICE PAYMENT AREAS BELOW NATIONAL AVERAGE.

Section 1853(c)(1) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(1) in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''; and

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

''(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

''(i) IN GENERAL.—For each year beginning with 2004, in the case of a Medicare+Choice payment area for which the Medicare+Choice capitation rate under this paragraph would otherwise be less than the United States per capita cost (USPCC), as calculated by the Secretary, a Medicare+Choice organization may negotiate with the Medicare Benefits Administrator an annual per capita rate that—

''(I) reflects an annual rate of increase up to the rate of increase specified in clause (ii);

''(II) takes into account audited current data supplied by the organization on its adjusted community rate (as defined in section 1854(f)(3)); and

''(III) does not exceed the United States per capita cost, as projected by the Secretary for the year involved.

''(ii) MAXIMUM RATE DESCRIBED.—The rate of increase specified in this clause for a year is the rate of inflation in private health insurance for the year involved, as projected by the Medicare Benefits Administrator, and includes such adjustments as may be necessary—

''(I) to reflect the demographic characteristics in the population under this title; and

''(II) to eliminate the costs of prescription drugs.

''(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.''.

SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED ON DATA FROM ALL SETTINGS.

Section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

''and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the methodology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.''.

Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including injectable and infusable drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

SEC. 312. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) REVISION OF MEDICARE COVERAGE FOR IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) (as amended by section 227(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1832 of the Social Security Act (42 U.S.C. 1395k) (as amended by section 227(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

(B) Subsections (c) and (d) of section 227 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–355), as enacted into law by section 1000(a)(6) of Public Law 106–113, are repealed.

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

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000, this subparagraph shall be applied without regard to any time limitation.''.

(c) ESTABLISHMENT OF PART D CATASTROPHIC LIMIT ON PART B COPAYMENTS FOR IMMUNOSUPPRESSIVE DRUGS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

''(p) LIMITATION ON AMOUNT OF DEDUCTIBLES AND COINSURANCE FOR IMMUNOSUPPRESSIVE DRUGS FOR CERTAIN BENEFICIARIES.—With respect to 2003 and each subsequent year, no deductibles and coinsurance applicable to immunosuppresive drugs (as described in section 1861(s)(2)(J)) in a year under this part shall be imposed to the extent that the individual has incurred expenditures in that year for out-of-pocket expenditures for immunosuppressive drugs in excess of the catastrophic benefit level provided for under section 1860B(c).''.

Subtitle C—Improvement of Certain Preventive Benefits

SEC. 321. COVERAGE OF ANNUAL SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) IN GENERAL.—

(1) ANNUAL SCREENING PAP SMEAR.—Section 1861(nn)(1) of the Social Security Act (42 U.S.C. 1395x(nn)(1)) is amended by striking ''if the individual involved has not had such a test during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3).'' and inserting ''if the woman involved has not had such a test during the preceding year.''.

(2) ANNUAL SCREENING PELVIC EXAM.—Section 1861(nn)(2) of such Act (42 U.S.C. 1395x(nn)(2)) is amended by striking ''during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3),'' and inserting ''during the preceding year,''.

(3) CONFORMING AMENDMENT.—Section 1861(nn) of such Act (42 U.S.C. 1395x(nn)) is amended by striking paragraph (3).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to items and services furnished on or after January 1, 2001.

TITLE IV—ADJUSTMENTS TO PAYMENT PROVISIONS OF THE BALANCED BUDGET ACT

Subtitle A—Payments for Inpatient Hospital Services

SEC. 401. ELIMINATING REDUCTION IN HOSPITAL MARKET BASKET UPDATE FOR FISCAL YEAR 2001.

Section 1886(b)(3)(B)(i)(XVI) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XVI)) is amended by striking ''minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,'' and inserting ''for hospitals in all areas,''.

SEC. 402. ELIMINATING FURTHER REDUCTIONS IN INDIRECT MEDICAL EDUCATION (IME) FOR FISCAL YEAR 2001.

Section 1886(d)(5)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)) is amended—

(1) in subclause (IV)—

(A) by striking ''fiscal year 2000'' and inserting ''each of fiscal years 2000 and 2001''; and

(B) by adding ''and'' at the end;

(2) by striking subclause (V); and

(3) by redesignating subclause (VI) as subclause (V).

SEC. 403. ELIMINATING FURTHER REDUCTIONS IN DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) MEDICARE PAYMENTS.—Section 1886(d)(5)(F)(ix) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

(1) in subclause (III), by striking ''and 2001'';

(2) by redesignating subclauses (IV) and (V) as subclauses (V) and (VI), respectively; and

(3) by inserting after subclause (III) the following new subclause:

''(IV) during fiscal year 2001, such additional payment amount shall be reduced by 0 percent;''.

(b) FREEZE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEAR 2001.—Notwithstanding section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r–4(f)(2)), the DSH allotment under such section for a State for fiscal year 2001 shall be the same as the DSH allotment under such section for fiscal year 2000.

SEC. 404. INCREASE BASE PAYMENT TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in clause (i), by striking ''October 1, 1997, 50 percent ('' and inserting ''October 1, 2000, 25 percent (for discharges between October 1, 1997 and September 30, 2000, 50 percent,''; and

(2) in clause (ii), in the matter preceding subclause (I), by striking ''after October 1, 1997, 50 percent ('' and inserting ''after October 1, 2000, 75 percent (for discharges between October 1, 1997, and September 30, 2000, 50 percent,''.

Subtitle B—Payments for Skilled Nursing Services

SEC. 411. ELIMINATING REDUCTION IN SNF MARKET BASKET UPDATE FOR FISCAL YEAR 2001.

Section 1888(e)(4)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)) is amended—

(1) by redesignating subclauses (II) and (III) as subclauses (III) and (IV) respectively;

(2) in subclause (III) as redesignated, by striking ''for each of fiscal years 2001 and 2002,'' and inserting ''for fiscal year 2002,''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) for fiscal year 2001, the rate computed for fiscal year 2000 increased by the skilled nursing facility market basket percentage increase for fiscal year 2000.''.

SEC. 412. EXTENSION OF MORATORIUM ON THERAPY CAPS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended in paragraph (4) by striking ''2000 and 2001.'' and inserting ''2000 through 2002.''.

Subtitle C—Payments for Home Health Services

SEC. 421. 1-YEAR ADDITIONAL DELAY IN APPLICATION OF 15 PERCENT REDUCTION ON PAYMENT LIMITS FOR HOME HEALTH SERVICES.

Section 1895(b)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

(1) by redesignating subparagraph (II) as subparagraph (III);

(2) by inserting in subparagraph (III), as redesignated, ''24 months'' following ''periods beginning''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).''.

SEC. 422. PROVISION OF FULL MARKET BASKET UPDATE FOR HOME HEALTH SERVICES FOR FISCAL YEAR 2001.

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

(1) by striking ''2001,''; and

(2) by adding at the end the following: ''With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket.''.

Subtitle D—Rural Provider Provisions

SEC. 431. ELIMINATION OF REDUCTION IN HOSPITAL OUTPATIENT MARKET BASKET INCREASE.

Section 1833(t)(3)(C)(iii) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking ''reduced by 1 percentage point for such factor for services furnished in each of 2000, 2001, and 2002'' and inserting ''reduced by 1 percentage point for such factor for services furnished in 2000 and reduced (except in the case of hospitals located in a rural area, as defined for purposes of section 1886(d)) by 1 percentage point for such factor for services furnished in each of 2001 and 2002.''

Subtitle E—Other Providers

SEC. 441. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

The last sentence of section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by striking ''for such services furnished on or after January 1, 2001, by 1.2 percent'' and inserting ''for such services furnished on or after January 1, 2001, by 2.4 percent''.

Subtitle F—Provision for Additional Adjustments

SEC. 451. GUARANTEE OF ADDITIONAL ADJUSTMENTS TO PAYMENTS FOR PROVIDERS FROM BUDGET SURPLUS.

Notwithstanding any other provision of law, from amounts estimated to be in excess social security surpluses estimated under the Balanced Budget and Emergency Deficit Control Act of 1985 for the 5 fiscal year and 10 fiscal year periods beginning in fiscal year 2001, there shall be made available for further adjustments to payment policies established by the Balanced Budget Act of 1997, amounts that would provide for additional improvements to the medicare and medicaid programs carried out under titles XVIII and XIX of the Social Security Act and payments to providers of services and suppliers furnishing items and services for which payments is made under those programs in the aggregate amounts over such 5 fiscal year and 10 fiscal year periods of $11,000,000, and $21,000,000, respectively.

PARLIAMENTARY INQUIRY

Mr. THOMAS (during the reading). Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from California (Mr. THOMAS) will state his parliamentary inquiry.

Mr. THOMAS. Mr. Speaker, under the rules, is the majority allowed a copy of the motion that the Clerk is reading? We do not have a motion, a copy of the motion.

The SPEAKER pro tempore. The Clerk will try and make copies available, but it is not a prerequisite.

The Clerk may proceed.

The Clerk continued reading the motion to recommit.

Mr. THOMAS (during the reading). Mr. Speaker, we have received a copy of the bill. We are familiar with it, and I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mr. DOGGETT. Mr. Speaker, reserving the right to object, on my reservation I believe that this is the same bill that was submitted to the Committee on Rules last night and the night before and that they rejected last night, or perhaps it was 2:30 or 3:00 this morning. It is the only genuine Medicare plan that is before us. We have been denied an opportunity to see it other than at this point. She is really in the reading just getting to the good part, which is the plan itself that will provide real benefit.

Mr. Speaker, I would object to suspending the reading.

Mr. THOMAS. Mr. Speaker, I withdraw my request.

The SPEAKER pro tempore. The Clerk will continue to read.

The Clerk continued reading the motion to recommit.

☐ 1845

Mr. KLECZKA (during the reading) Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore (Mr. LAHOOD). Is there objection to the request of the gentleman from Wisconsin?

Mr. DOGGETT. Mr. Speaker, reserving the right to object, subject to my reservation, I believe the part that was being read regards the ability of any citizen under the Medicare program to be able to go out to their own pharmacy. There will be, under this plan, the right for a guaranteed benefit instead of the ploy that we have heard about all day that is really the product of the public relations firm.

Mr. THOMAS. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will read.

The Clerk continued reading the motion to recommit.

PARLIAMENTARY INQUIRY

Mr. JACKSON of Illinois (during the reading). Mr. Speaker, may I make a parliamentary inquiry?

The SPEAKER pro tempore. The gentleman may state his parliamentary inquiry.

Mr. JACKSON of Illinois. Mr. Speaker, do the rules of the House provide an opportunity for the reader to have relief over the next hour?

The SPEAKER pro tempore. The Clerk's office takes care of people very well.

Mr. JACKSON of Illinois. Mr. Speaker, then I would like to make a motion that the reading be dispensed with.

The SPEAKER pro tempore. That is not in order.

The Clerk will proceed.

The Clerk continued reading the motion to recommit.

☐ 1945

Mr. STARK (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore (Mr. LAHOOD). Is there objection to the request of the gentleman from California?

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. STARK) for 5 minutes.

Mr. STARK. Mr. Speaker, this plan does what should be done for our seniors. It provides that there will be benefits far in excess of the Republican plan. There is no deductible that pays half the cost.

POINT OF ORDER

The SPEAKER pro tempore. The gentleman from California (Mr. STARK) will suspend.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, I had reserved points of order against the measure.

The SPEAKER pro tempore. The gentleman from California (Mr. THOMAS) has reserved the point of order and is recognized on his point of order.

Mr. THOMAS. Mr. Speaker, I raise a point of order against the motion on the grounds that it violates section 302(f) of the Budget Act which prohibits consideration of legislation that would exceed the Committee on Ways and Means allocation of New Budget Authority for the period of 2001 to 2005.

The SPEAKER pro tempore. It is proper for the gentleman from California to insist on his point of order.

Mr. STARK. Mr. Speaker, may I be heard on the point of order?

The SPEAKER pro tempore. The gentleman may be heard.

Mr. STARK. Mr. Speaker, I ask the Speaker's brief indulgence as this is a complex issue, but it is important to the seniors in our country.

Mr. Speaker, this Republican resolution has all points of order waived, and we have none. The budget resolution which the Republicans have created

that makes our hundred billion dollar bill out of order does not comport with what the Republicans have done to provide tax cuts for the wealthiest.

For example, there is $661,000 each for the wealthiest Americans under a tax cut, and yet only $460 a year for senior citizens in prescription drugs. That basically gets to the heart of why I would object to the gentleman's point of order against our bill.

There is a doctrine. It is clearly not fair. We have no points of order waived, and they do.

I think it was Asher Hinds' for Speaker Jubilation Cornpone in 1867 on a cold Thanksgiving evening who ruled on an issue of fairness, and I think it was Speaker Cornpone's statement, that goose again. What is sauce for the goose is sauce for the gander. Parliamentarian Cannon-Deschler Precedents have carried this fairness doctrine down to today.

So, Mr. Speaker, I would like to object to the point of order on the grounds of fairness that has been established in this House for over 100 years and urge that the Speaker rule to allow the Democrats to present a plan which is arguably better than the Republican plan. Based on fairness, I do urge that the point of order is overridden.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, am I allowed to speak on the point of order, or would it be appropriate for others to speak?

The SPEAKER pro tempore. The gentleman from California may proceed.

Mr. THOMAS. Mr. Speaker, I am tempted to use the statement of the gentleman from California (Mr. STARK) who conceded that it was, in fact, in violation of the Budget Act, but I believe the Chair is in possession of a statement from the chairman on the Committee of the Budget which, in fact, supports the point of order that has been presented. Therefore, I would insist on my point of order.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Rhode Island (Mr. WEYGAND).

Mr. WEYGAND. Mr. Speaker, may I be heard on the point of order?

The SPEAKER pro tempore. The gentleman from Rhode Island may proceed.

Mr. WEYGAND. Mr. Speaker, as a member of the Committee on the Budget, I know that the Committee on the Budget went through much frustration with regard to the concept that the Republicans are floating before us till now with regard to a prescription drug plan.

They had allocated, in a very unusual way, about $40 billion based upon CBO estimates for anticipated surpluses and monies that would be available for such expenditures. The fact of the matter is that, over the last week and half, if we are talking about fairness, is the amount of surplus has been more than doubled even by CBO.

So the basic premise for which the budget resolution and the Committee on the Budget deliberated is no longer valid because the amount of money that has been realized for the surplus is far more than what we realized when we first had those budget deliberations.

In true fairness, if we are to look at this particular legislation that we are proposing, one should look at the fairness of the amount of surplus that is presently available to the Committee on the Budget. If indeed we are going to be fair, the chairman of the Committee on the Budget should reconvene the whole committee to take a look at exactly what truly is a surplus and, therefore, what could be spent on various other items, including a prescription drug benefit.

We seek only to provide our seniors with a cost-effective way of providing for prescription drugs. I believe many of the people on the other side also want to do that. But what we propose is a system that will clearly work, will not be putting it into an insurance company program, but into a Medicare universal program that will be available to all seniors.

I ask them to consider not raising this point of order, and I hope that we will dismiss with this point of order.

Mr. RANGEL. Mr. Speaker, may I be heard on the point of order?

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York.

Mr. RANGEL. Mr. Speaker, it just seems to me that, whether one is Republican or Democrat, that we all have at least the same concern for our older Americans who, as they get older, more susceptible to illness and pain, we have done a pretty good job with Medicare and giving older people access to doctors and to hospitals. Even initially those people who did not like the program would have to admit that it has really removed a lot of pain for some deserving Americans.

Now, we reach the point in saying, what good is access to health care if after the doctors prescribed the medicine to keep one well, that one cannot afford to do it.

Well, it was easy for us to say that we had to establish priorities. We always had the Communist threat. We always had to invest in defense. But now when everybody agrees that, no matter who takes the credit for it, we have an opportunity really, not to pick and choose which are the winners and losers among the older people, but to be able to say we thank them for the investments that they have made in this great Republic. They are aged, but they are not forgotten; and that we trust them enough that we will take some of this surplus and make them whole so that they will never have to worry about not paying their rent or their mortgage or getting the foods that they need because they had to pay for their medicine.

It seems to me that it may be that the majority, from a technical point of view, may be correct. But I think the American people would know or should know that the majority holds in its hands this evening the ability to waive that point of order and to say that they are prepared to do what is right, what is moral, and what is in their power to do.

I just hope that the gentleman from California (Mr. THOMAS) would be sensitive enough to at least consider at this point in time waiving the point of order so that we can give a better deal to those older people who deserve it.

☐ 2000

The SPEAKER pro tempore (Mr. LAHOOD). The Chair is prepared to rule.

The gentleman from California (Mr. THOMAS) makes a point of order that the amendment proposed by the instructions in the motion to recommit offered by the gentleman from California (Mr. STARK) violates section 302(f) of the Congressional Budget Act of 1974.

Section 302(f) of the Budget Act prescribes a point of order against consideration of an amendment providing new budget authority if the adoption of the amendment and enactment of the bill, as amended, would cause the pertinent allocation of new budget authority for the relevant fiscal years under section 302(a) of the Act to be exceeded.

The Chair is authoritatively guided by estimates provided by the Committee on the Budget indicating that (1) any amendment that proposes to provide new budget authority in excess of $2.964 billion over the amount provided by the underlying bill for the period of fiscal years 2001 through 2005 would exceed the section 302(a) allocation of the Committee on Ways and Means, as adjusted under section 214 of House Concurrent Resolution 290, in violation of section 302(f) of the Congressional Budget Act of 1974; and

(2) the bill, as it is proposed to be changed by the amendment, would so cause the new budget authority provided by the bill to exceed that level.

The Chair therefore holds that the amendment violates section 302(f) of the Budget Act. Accordingly, the point of order is sustained and the motion to recommit is not in order.

Mr. WEYGAND. Mr. Speaker, I respectfully disagree with the Chair's ruling and appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is, Shall the decision of the Chair stand as the judgment of the House?

MOTION TO TABLE OFFERED BY MR. THOMAS

Mr. THOMAS. Mr. Speaker, I move to table the motion to appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. THOMAS) to lay on the table the appeal of the ruling of the Chair.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. STARK. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 224, nays 202, not voting 8, as follows:

[Roll No. 355]

YEAS—224

Aderholt	Goodlatte	Peterson (PA)
Archer	Goodling	Petri
Armey	Goss	Pickering
Bachus	Graham	Pitts
Baker	Granger	Pombo
Ballenger	Green (WI)	Porter
Barr	Greenwood	Portman
Barrett (NE)	Gutknecht	Pryce (OH)
Bartlett	Hansen	Quinn
Barton	Hastings (WA)	Radanovich
Bass	Hayes	Ramstad
Bateman	Hayworth	Regula
Bereuter	Hefley	Reynolds
Biggert	Herger	Riley
Bilbray	Hill (MT)	Rogan
Bilirakis	Hilleary	Rogers
Bliley	Hobson	Rohrabacher
Blunt	Hoekstra	Ros-Lehtinen
Boehlert	Horn	Roukema
Boehner	Hostettler	Royce
Bonilla	Houghton	Ryan (WI)
Bono	Hulshof	Ryun (KS)
Brady (TX)	Hunter	Salmon
Bryant	Hutchinson	Sanford
Burr	Hyde	Saxton
Burton	Isakson	Scarborough
Buyer	Istook	Schaffer
Callahan	Jenkins	Sensenbrenner
Calvert	Johnson (CT)	Sessions
Camp	Johnson, Sam	Shadegg
Campbell	Jones (NC)	Shaw
Canady	Kasich	Shays
Cannon	Kelly	Sherwood
Castle	King (NY)	Shimkus
Chabot	Kingston	Shuster
Chambliss	Knollenberg	Simpson
Chenoweth-Hage	Kolbe	Skeen
Coble	Kuykendall	Smith (MI)
Coburn	LaHood	Smith (NJ)
Collins	Largent	Smith (TX)
Combest	Latham	Souder
Cooksey	LaTourette	Spence
Cox	Lazio	Stearns
Crane	Leach	Stump
Cubin	Lewis (CA)	Sununu
Cunningham	Lewis (KY)	Sweeney
Davis (VA)	Linder	Talent
Deal	LoBiondo	Tancredo
DeLay	Lucas (OK)	Tauzin
DeMint	Manzullo	Taylor (NC)
Diaz-Balart	Martinez	Terry
Dickey	McCollum	Thomas
Doolittle	McCrery	Thornberry
Dreier	McHugh	Thune
Duncan	McInnis	Tiahrt
Dunn	McIntosh	Toomey
Ehlers	McKeon	Traficant
Ehrlich	Metcalf	Upton
Emerson	Mica	Vitter
English	Miller (FL)	Walden
Everett	Miller, Gary	Walsh
Ewing	Moran (KS)	Wamp
Fletcher	Morella	Watkins
Foley	Myrick	Watts (OK)
Fossella	Nethercutt	Weldon (FL)
Franks (NJ)	Ney	Weldon (PA)
Frelinghuysen	Northup	Weller
Gallegly	Norwood	Whitfield
Ganske	Nussle	Wicker
Gekas	Ose	Wilson
Gibbons	Oxley	Wolf
Gilchrest	Packard	Wu
Gillmor	Paul	Young (AK)
Gilman	Pease	Young (FL)
Goode	Peterson (MN)	

NAYS—202

Abercrombie	Baird	Becerra
Ackerman	Baldacci	Bentsen
Allen	Baldwin	Berkley
Andrews	Barcia	Berman
Baca	Barrett (WI)	Berry
Bishop	Hoeffel	Olver
Blagojevich	Holden	Ortiz
Blumenauer	Holt	Owens
Bonior	Hooley	Pallone
Borski	Hoyer	Pascrell
Boswell	Inslee	Pastor
Boucher	Jackson (IL)	Payne
Boyd	Jackson-Lee (TX)	Pelosi
Brady (PA)	John	Phelps
Brown (FL)	Johnson, E. B.	Pickett
Brown (OH)	Jones (OH)	Pomeroy
Capps	Kanjorski	Price (NC)
Capuano	Kaptur	Rahall
Cardin	Kennedy	Rangel
Carson	Kildee	Reyes
Clay	Kilpatrick	Rivers
Clayton	Kind (WI)	Rodriguez
Clement	Kleczka	Roemer
Clyburn	Klink	Rothman
Condit	Kucinich	Roybal-Allard
Conyers	LaFalce	Rush
Costello	Lampson	Sabo
Coyne	Lantos	Sanchez
Cramer	Larson	Sanders
Crowley	Lee	Sandlin
Cummings	Levin	Sawyer
Danner	Lewis (GA)	Schakowsky
Davis (FL)	Lipinski	Scott
Davis (IL)	Lofgren	Sherman
DeFazio	Lowey	Shows
DeGette	Lucas (KY)	Sisisky
Delahunt	Luther	Skelton
DeLauro	Maloney (CT)	Slaughter
Deutsch	Maloney (NY)	Smith (WA)
Dicks	Mascara	Snyder
Dingell	Matsui	Spratt
Dixon	McCarthy (MO)	Stabenow
Doggett	McCarthy (NY)	Stark
Dooley	McDermott	Stenholm
Doyle	McGovern	Strickland
Edwards	McIntyre	Stupak
Engel	McKinney	Tanner
Eshoo	McNulty	Tauscher
Etheridge	Meehan	Taylor (MS)
Evans	Meek (FL)	Thompson (CA)
Farr	Meeks (NY)	Thompson (MS)
Fattah	Menendez	Thurman
Forbes	Millender-McDonald	Tierney
Ford	Miller, George	Towns
Frank (MA)	Minge	Turner
Frost	Mink	Udall (CO)
Gejdenson	Moakley	Udall (NM)
Gephardt	Mollohan	Velazquez
Gonzalez	Moore	Visclosky
Gordon	Moran (VA)	Waters
Green (TX)	Murtha	Watt (NC)
Gutierrez	Nadler	Waxman
Hall (OH)	Napolitano	Weiner
Hall (TX)	Neal	Wexler
Hastings (FL)	Oberstar	Weygand
Hill (IN)	Obey	Wise
Hilliard	Olver	Woolsey
Hinchey	Ortiz	Wynn

NOT VOTING—8

Cook	Hinojosa	Serrano
Filner	Jefferson	Vento
Fowler	Markey	

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Messrs. UDALL of Colorado, WYNN, SNYDER, and SPRATT changed their vote from ''yea'' to ''nay.''

Mr. BALLENGER and Mrs. BIGGERT changed their vote from ''nay'' to ''yea.''

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MOTION TO RECOMMIT OFFERED BY MR. STARK

Mr. STARK. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore (Mr. LAHOOD). Is the gentleman opposed to the bill?

Mr. STARK. I am, Mr. Speaker, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. STARK of California moves to recommit the bill H.R. 4680 to the Committee on Ways and Means with instructions to report the same back to the House promptly with a Medicare prescription medicine plan that accomplishes the following by, among other things, the amendment-in-the-nature-of-a-substitute specified below:

(1) Provide a benefit which is available to all medicare beneficiaries, including those in rural areas.

(2) Provide equal treatment for all medicare beneficiaries, without disparities in coverage between rural, urban, and suburban regions, and without compounding current disparities in coverage.

(3) Ensure that medicare beneficiaries receive a price substantially similar to the best prices paid by preferred customers for their prescription medications.

(4) Help low and middle-income medicare beneficiaries afford prescription medicine costs.

(5) Allow participation by local pharmacists, not just mail order pharmacies.

(6) Be consistent with medicare modernization.

The amendment-in-the-nature-of-a-substitute is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000''.

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

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Prescription medicine coverage was not a standard part of health insurance when the medicare program under title XVIII of the Social Security Act was enacted in 1965. Since 1965, however, medicine coverage has become a key component of most private and public health insurance coverage, except for the medicare program.

(2) At least ⅔ of medicare beneficiaries have unreliable, inadequate, or no medicine coverage at all.

(3) Seniors who do not have medicine coverage typically pay, at a minimum, 15 percent more than people with coverage.

(4) Medicare beneficiaries at all income levels lack prescription medicine coverage, with more than ½ of such beneficiaries having incomes greater than 150 percent of the poverty line.

(5) The number of private firms offering retiree health coverage is declining.

(6) Medigap premiums for medicines are too expensive for most beneficiaries and are highest for older senior citizens, who need prescription medicine coverage the most and typically have the lowest incomes.

(7) While the management of a medicare prescription medicine benefit program should mirror the practices employed by benefit administrators in delivering prescription medicines, the Secretary of Health and Human Services should oversee that program to assure that a guaranteed and defined prescription drug benefit is provided to all medicare beneficiaries.

(8) All medicare beneficiaries should have access to a voluntary, reliable, affordable, dependable, and defined outpatient medicine benefit as part of the medicare program that assists with the high cost of prescription medicines and protects them against excessive out-of-pocket costs.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT PROGRAM

SEC. 101. PRESCRIPTION MEDICINE BENEFIT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED

''ESTABLISHMENT OF DEFINED PRESCRIPTION MEDICINE BENEFIT PROGRAM FOR THE AGED AND DISABLED UNDER THE MEDICARE PROGRAM

''SEC. 1860. (a) IN GENERAL.—There is established as a part of the medicare program under this title a voluntary insurance program to provide defined prescription medicine benefits, including pharmacy services, in accordance with the provisions of this part for individuals who are aged or disabled or have end-stage renal disease and who voluntarily elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

''(b) NONINTERFERENCE BY THE SECRETARY.—In administering the prescription medicine benefit program established under this part, the Secretary may not—

''(1) require a particular formulary, institute a price structure for benefits, or in any way ration benefits;

''(2) interfere in any way with negotiations between benefit administrators and medicine manufacturers, or wholesalers; or

''(3) otherwise interfere with the competitive nature of providing a prescription medicine benefit using private benefit administrators, except as is required to guarantee coverage of the defined benefit.

''SCOPE OF DEFINED BENEFITS; COVERAGE OF ALL MEDICALLY NECESSARY PRESCRIPTION MEDICINES

''SEC. 1860A. (a) IN GENERAL.—The benefits provided to an individual enrolled in the insurance program under this part shall consist of—

''(1) payments made, in accordance with the provisions of this part, for covered prescription medicines (as specified in subsection (b)) dispensed by any pharmacy participating in the program under this part (and, in circumstances designated by the benefit administrator, by a nonparticipating pharmacy); and

''(2) charging by pharmacies of the negotiated discount price—

''(A) for all covered prescription medicines, without regard to basic benefit limitation specified in section 1860B(b)(3); and

''(B) established with respect to any drugs or classes of drugs described in subparagraphs (A), (B), (D), (E), or (F) of section 1927(d)(2) that are available to individuals receiving benefits under this title.

''(b) COVERED PRESCRIPTION MEDICINES.—

''(1) IN GENERAL.—Covered prescription medicines, for purposes of this part, include all prescription medicines (as defined in section 1860J(1)), including smoking cessation agents, except as otherwise provided in this subsection.

''(2) EXCLUSIONS FROM COVERAGE.—Covered prescription medicines shall not include drugs or classes of drugs described in subparagraphs (A) through (D) and (F) through (H) of section 1927(d)(2) unless specifically provided otherwise by the Secretary with respect to a drug in any of such classes.

''(3) NONDUPLICATION OF PRESCRIPTION MEDICINES COVERED UNDER PART A OR B.—A medicine prescribed for an individual that would otherwise be a covered prescription medicine under this part shall not be so considered to the extent that payment for such medicine is available under part A or B (including all injectable drugs and biologicals for which payment was made or should have been made by a carrier under section 1861(s)(2) (A) or (B) as of the date of enactment of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000). Medicines otherwise covered under part A or B shall be covered under this part to the extent that benefits under part A or B are exhausted.

''(4) STUDY ON INCLUSION OF HOME INFUSION THERAPY SERVICES.—Not later than one year after the date of the enactment of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000, the Secretary shall submit to Congress a legislative proposal for the delivery of home infusion therapy services under this title and for a system of payment for such a benefit that coordinates items and services furnished under part B and under this part.

''PAYMENT OF DEFINED BASIC AND CATASTROPHIC BENEFITS

''SEC. 1860B. (a) PAYMENT OF BENEFITS.—There shall be paid from the Prescription Medicine Insurance Account within the Supplementary Medical Insurance Trust Fund, in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription medicines in a calendar year, the sum of the benefit amounts under subsections (b) and (c).

''(b) BASIC BENEFIT.—

''(1) IN GENERAL.—An amount (not exceeding 50 percent of the annual limitation under paragraph (3)) equal to the applicable government percentage (specified in paragraph (2)) of the negotiated price for each such covered prescription medicine or such higher percentage as is proposed under section 1860G(d)(9).

''(2) APPLICABLE GOVERNMENT PERCENTAGE.—The applicable government percentage specified in this paragraph is 50 percent or such higher percentage as may be proposed under section 1860G(d)(9), if the Secretary finds that such higher percentage will not increase aggregate costs to the Prescription Medicine Insurance Account.

''(3) ANNUAL LIMITATION IN BASIC BENEFIT.—

''(A) FOR 2003 THROUGH 2009.—For purposes of the basic benefit described in paragraph (1), the annual limitation under this paragraph is—

''(i) $2,000 for each of 2003, 2004, and 2005;

''(ii) $3,000 for 2006;

''(iii) $4,000 for each of 2007 and 2008; and

''(iv) $5,000 for 2009.

''(B) FOR 2010 AND SUBSEQUENT YEARS.—For purposes of paragraph (1), the annual limitation under this paragraph for 2010 and each subsequent year is equal to the limitation for the preceding year adjusted by the annual percentage increase in average per capita aggregate expenditures for covered outpatient medicines in the United States for medicare beneficiaries, as estimated by the Secretary. Any amount determined under this subparagraph that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(c) CATASTROPHIC BENEFIT.—

''(1) IN GENERAL.—With respect to out-of-pocket expenditures incurred by a beneficiary enrolled under this part in a year specified in paragraph (2), the amount of such expenditures that exceeds the catastrophic benefit level specified in paragraph (3).

''(2) APPLICATION IN A YEAR.—A year specified in this paragraph is—

''(A) any year (during the period beginning with 2003 and ending with 2005) for which the certification described in section 501 of the Medicare Guaranteed and Defined Rx Benefit and Health Provider Relief Act of 2000 has been made; and

''(B) 2006 and any subsequent year.

''(3) CATASTROPHIC BENEFIT LIMIT.—

''(A) FOR 2003.—The catastrophic benefit level specified in this paragraph for 2003 is $4,000.

''(B) INDEXING FOR SUBSEQUENT YEARS.—For a year after 2003, the catastrophic benefit level specified in this paragraph is the catastrophic benefit level specified in this paragraph for the previous year increased by annual percentage increase determined for the year involved under subsection (b)(3)(B). Any such amount which is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''ELIGIBILITY AND ENROLLMENT

''SEC. 1860C. (a) ELIGIBILITY.—Every individual who, in or after 2003, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll in the insurance program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by regulations.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section applied to this part, except as otherwise explicitly provided in this part.

''(2) SINGLE ENROLLMENT PERIOD.—Except as provided in section 1837(i) (as such section applies to this part), 1860E (relating to loss of coverage under the medicaid program), or 1860H(e) (relating to loss of employer or union coverage), or as otherwise explicitly provided, no individual shall be entitled to enroll in the program under this part at any time after the initial enrollment period without penalty, and in the case of all other late enrollments, the Secretary shall develop a late enrollment penalty for the individual that fully recovers the additional actuarial risk involved in providing coverage for the individual.

''(3) SPECIAL ENROLLMENT PERIOD IN 2003.—

''(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2003 may, at any time on or before December 31, 2003—

''(i) enroll in the program under this part; and

''(ii) enroll or reenroll in such program after having previously declined or terminated enrollment in such program.

''(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

''MONTHLY PREMIUM; INITIAL $25 PREMIUM

''SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF GUARANTEED SINGLE RATE FOR ALL PARTICIPATING BENEFICIARIES.—

''(1) $25 MONTHLY PREMIUM RATE IN 2003.—The monthly premium rate in 2003 for prescription medicine benefits under this part is $25.

''(2) PREMIUM RATES IN SUBSEQUENT YEARS.—

''(A) IN GENERAL.—The Secretary shall, during September of 2003 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this paragraph.

''(B) DETERMINATION OF ANNUAL BENEFIT COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits (but not including catastrophic benefits under section 1860B(c)) that will be payable from the Prescription Medicine Insurance Account for prescription medicines dispensed in such calendar year with respect to enrollees in the program under this part. In calculating such amount, the Secretary shall include an appropriate amount for a contingency margin.

''(C) DETERMINATION OF MONTHLY PREMIUM RATES.—

''(i) IN GENERAL.—The Secretary shall determine the monthly premium rate with respect to such enrollees for such succeeding year, which shall be 1/12 of the share specified in clause (ii) of the amount determined under subparagraph (B), divided by the total number of such enrollees, and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) ENROLLEE AND EMPLOYER PERCENTAGE SHARES.—The share specified in this clause, for purposes of clause (i), shall be—

''(I) one-half, in the case of premiums paid by an individual enrolled in the program under this part; and

''(II) two-thirds, in the case of premiums paid for such an individual by a former employer (as defined in section 1860H(f)(2)).

''(D) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under this paragraph.

''(b) PAYMENT OF PREMIUMS.—

''(1) GENERALLY THROUGH DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

''(A) IN GENERAL.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a), (b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

''(B) TRANSFERS OF DEDUCTION TO ACCOUNT.—The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Prescription Medicine Insurance Account from the appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

''(2) OTHERWISE THROUGH DIRECT PAYMENTS BY ENROLLEE TO SECRETARY.—

''(A) IN THE CASE OF INADEQUATE DEDUCTION.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

''(B) OTHER CASES.—An individual enrolled in the insurance program under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe.

''(C) DEPOSIT OF PREMIUMS IN ACCOUNT.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund.

''(c) CERTAIN LOW-INCOME INDIVIDUALS.—For rules concerning premiums for certain low-income individuals, see section 1860E.

''PRESCRIPTION MEDICINE INSURANCE ACCOUNT

''SEC. 1860F. (a) ESTABLISHMENT.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by

section 1841 an account to be known as the 'Prescription Medicine Insurance Account' (in this section referred to as the 'Account').

''(b) AMOUNTS IN ACCOUNT.—

''(1) IN GENERAL.—The Account shall consist of—

''(A) such amounts as may be deposited in, or appropriated to, such fund as provided in this part; and

''(B) such gifts and bequests as may be made as provided in section 201(i)(1).

''(2) SEPARATION OF FUNDS.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

''(c) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts, subject to appropriations, as the Secretary certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''ADMINISTRATION OF BENEFITS

''SEC. 1860G. (a) ADMINISTRATION.—

''(1) USE OF PRIVATE BENEFIT ADMINISTRATORS AS PROVIDED FOR UNDER PARTS A AND B.—The Secretary shall provide for administration of the benefits under this part through a contract with a private benefit administrator designated in accordance with subsection (c), for enrolled individuals residing in each service area designated pursuant to subsection (b) (other than such individuals enrolled in a Medicare+Choice program under part C), in accordance with the provisions of this section.

''(2) GUARANTEE OF PROGRAM ADMINISTRATION.—In the case of a service area in which no private benefit administrator has entered into a contract with the Secretary under paragraph (1) for the administration of this part, the Secretary shall seek to enter into a contract with a fiscal intermediary under part A (with a contract under section 1816) or a carrier under part B (with a contract under section 1842) to administer this part in that service area in accordance with the provisions of subsection (d). If the Secretary is unable to enter into such a contract for that service area, the Secretary shall provide for the administration of this part in that service area in accordance with the provisions of subsection (d) through another benefit administrator.

''(b) DESIGNATION OF GEOGRAPHIC SERVICE AREAS.—

''(1) IN GENERAL.—The Secretary shall divide the total geographic area served by the programs under this title into an appropriate number of service areas for purposes of administration of benefits under this part.

''(2) CONSIDERATIONS IN DETERMINING SERVICE AREAS.—In determining or adjusting the number and boundaries of service areas under this subsection, the Secretary shall seek to ensure that—

''(A) there is a reasonable level of competition among entities eligible to contract to administer the benefit program under this section for each area; and

''(B) the designation of areas is consistent with the goal of securing contracts under this section that use the volume purchasing power of enrollees to obtain the same or similar type of prescription medicine discounts as are afforded favored, large purchasers.

''(c) DESIGNATION OF BENEFIT ADMINISTRATOR.—

''(1) AWARD AND DURATION OF CONTRACT.—

''(A) COMPETITIVE AWARD.—Each contract for a service area shall be awarded competitively in accordance with section 5 of title 41, United States Code, for a period (subject to subparagraph (B)) of not less than 2 nor more than 5 years.

''(B) REVIEW.—A contract for a service area shall be subject to an evaluation after a year and termination for cause.

''(2) ELIGIBLE BENEFIT ADMINISTRATORS.—An entity shall not be eligible for consideration as a benefit administrator responsible for administering the prescription medicine benefit program under this part in a service area unless it meets at least the following criteria:

''(A) TYPE OF ENTITY.—The entity shall be capable of administering a prescription medicine benefit program, and may be a prescription medicine vendor, wholesale and retail pharmacy delivery system, health care provider or insurer, any other type of entity as the Secretary may specify, or a consortium of such entities.

''(B) PERFORMANCE CAPABILITY.—The entity shall have sufficient expertise, personnel, and resources to perform effectively the benefit administration functions for such area.

''(C) FINANCIAL INTEGRITY.—The entity and its officers, directors, agents, and managing employees shall have a satisfactory record of professional competence and professional and financial integrity, and the entity shall have adequate financial resources to perform services under the contract without risk of insolvency.

''(3) PROPOSAL REQUIREMENTS.—

''(A) IN GENERAL.—An entity's proposal for award or renewal of a contract under this section shall include such material and information as the Secretary may require.

''(B) SPECIFIC INFORMATION.—A proposal described in subparagraph (A) shall—

''(i) include a detailed description of—

''(I) the schedule of negotiated prices that will be charged to enrollees;

''(II) how the entity will deter medical errors that are related to prescription medicines; and

''(III) proposed contracts with local pharmacy providers designed to ensure access, including compensation for local pharmacists' services;

''(ii) be accompanied by such information as the Secretary may require on the entity's past performance; and

''(iii) disclose ownership and shared financial interests with other entities involved in the delivery of the benefit as proposed.

''(4) CRITERIA FOR COMPETITIVE SELECTION.—In awarding a contract competitively, the Secretary shall consider the comparative merits of each of the applications by eligible entities, as determined on the basis of the entities' past performance and other relevant factors, with respect to the following:

''(A) the estimated total cost of the contract, taking into consideration the entity's proposed fees and price and cost estimates, as evaluated and adjusted by the Secretary in accordance with the provisions of the Federal Acquisition Regulation concerning contracting by negotiation;

''(B) prior experience in administering a type of health insurance program;

''(C) effectiveness in containing costs through obtaining discounts from manufacturers, pricing incentives, utilization management, and drug utilization review;

''(D) the quality and efficiency of benefit management services with respect to such matters as claims processing and benefits coordination; record-keeping and reporting; maintenance of medical records confidentiality; and drug utilization review, patient information, customer satisfaction, and other activities supporting quality of care; and

''(E) such other factors as the Secretary deems necessary to evaluate the merits of each application.

''(5) FLEXIBILITY IN SECURING BEST BENEFIT ADMINISTRATOR.—In awarding contracts under this subsection, the Secretary may waive conflict of interest rules generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the purposes of the programs under this title and the best interests of enrolled individuals; and

''(B) will permit a sufficient level of competition for such contracts, promote efficiency of benefits administration, or otherwise serve the objectives of the program under this part.

If the Secretary waives such rules, the Secretary shall establish a special monitoring program to ensure that beneficiaries served by the benefit administrator have access to all necessary pharmaceuticals as prescribed.

''(6) MAXIMIZING COMPETITION AND SAVINGS.—In awarding contracts under this section, the Secretary shall give consideration to the need to maintain sufficient numbers of entities eligible and willing to administer benefits under this part to ensure vigorous competition for such contracts, while also giving consideration to the need for a benefit administrator to have sufficient purchasing power to obtain appropriate cost savings.

''(d) FUNCTIONS OF BENEFIT ADMINISTRATOR.—A benefit administrator for a service area shall (or in the case of the function described in paragraph (9), may) perform the following functions:

''(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

''(A) PRIVATELY NEGOTIATED PRICES.—Each benefit administrator shall establish, through negotiations with medicine manufacturers and wholesalers and pharmacies, a schedule of prices for covered prescription medicines.

''(B) AGREEMENTS WITH ANY WILLING PHARMACY.—Each benefit administrator shall enter into participation agreements under subsection (e) with any willing pharmacy, that include terms that—

''(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access);

''(ii) permit the participation of any willing pharmacy in the service area that meets the participation requirements described in subsection (e); and

''(iii) allow for reasonable dispensing and consultation fees for pharmacies.

''(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Each benefit administrator shall ensure that the negotiated prices established under subparagraph (A) and the list of pharmacies with agreements under subsection (e) are regularly updated and readily available in the service area to health care professionals authorized to prescribe medicines, participating pharmacies, and enrolled individuals.

''(2) TRACKING OF COVERED ENROLLED INDIVIDUALS.—In coordination with the Secretary, each benefit administrator shall maintain accurate, updated records of all enrolled individuals residing in the service area (other than individuals enrolled in a plan under part C).

''(3) PAYMENT AND COORDINATION OF BENEFITS.—

''(A) PAYMENT.—Each benefit administrator shall—

''(i) administer claims for payment of benefits under this part and encourage, to the

maximum extent possible, use of electronic means for the submissions of claims;

''(ii) determine amounts of benefit payments to be made; and

''(iii) receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

''(B) COORDINATION.—Each benefit administrator shall coordinate with the Secretary, other benefit administrators, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of access to and payment for covered prescription medicines according to an individual's in-service area plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

''(C) EXPLANATION OF BENEFITS.—Each benefit administrator shall furnish to enrolled individuals an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription medicine benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(4) REQUIREMENTS WITH RESPECT TO FORMULARIES.—If a benefit administrator uses a formulary to contain costs under this part, the benefit administrator shall—

''(A) use a pharmacy and therapeutics committee comprised of licensed practicing physicians, pharmacists, and other health care practitioners to develop and manage the formulary;

''(B) include in the formulary at least 1 medicine from each therapeutic class and, if available, a generic equivalent thereof; and

''(C) disclose to current and prospective enrollees and to participating providers and pharmacies in the service area, the nature of the formulary restrictions, including information regarding the medicines included in the formulary and any difference in cost-sharing amounts.

''(5) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Each benefit administrator shall have in place effective cost and utilization management, drug utilization review, quality assurance measures, and systems to reduce medical errors, including at least the following, together with such additional measures as the Secretary may specify:

''(A) DRUG UTILIZATION REVIEW.—A drug utilization review program conforming to the standards provided in section 1927(g)(2) (with such modifications as the Secretary finds appropriate).

''(B) FRAUD AND ABUSE CONTROL.—Activities to control fraud, abuse, and waste, including prevention of diversion of pharmaceuticals to the illegal market.

''(C) MEDICATION THERAPY MANAGEMENT.—

''(i) IN GENERAL.—A program of medicine therapy management and medication administration that is designed to assure that covered outpatient medicines are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS OF MEDICATION THERAPY MANAGEMENT.—Such program may include—

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

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

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

''(iv) CONSIDERATIONS IN PHARMACY FEES.—The benefit administrators shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(6) EDUCATION AND INFORMATION ACTIVITIES.—Each benefit administrator shall have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription medicine benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

''(7) BENEFICIARY PROTECTIONS.—

''(A) CONFIDENTIALITY OF HEALTH INFORMATION.—Each benefit administrator shall have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Secretary may prescribe.

''(B) GRIEVANCE AND APPEAL PROCEDURES.—Each benefit administrator shall have in place such procedures as the Secretary may specify for hearing and resolving grievances and appeals, including expedited appeals, brought by enrolled individuals against the benefit administrator or a pharmacy concerning benefits under this part, which shall include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

''(8) RECORDS, REPORTS, AND AUDITS OF BENEFIT ADMINISTRATORS.—

''(A) RECORDS AND AUDITS.—Each benefit administrator shall maintain adequate records, and afford the Secretary access to such records (including for audit purposes).

''(B) REPORTS.—Each benefit administrator shall make such reports and submissions of financial and utilization data as the Secretary may require taking into account standard commercial practices.

''(9) PROPOSAL FOR ALTERNATIVE COINSURANCE AMOUNT.—

''(A) SUBMISSION.—Each benefit administrator may submit a proposal for decreased beneficiary cost-sharing for generic prescription medicines, prescription medicines on the benefit administrator's formulary, or prescription medicines obtained through mail order pharmacies.

''(B) CONTENTS.—The proposal submitted under subparagraph (A) shall contain evidence that such decreased cost-sharing would not result in an increase in aggregate costs to the Account, including an analysis of differences in projected drug utilization patterns by beneficiaries whose cost-sharing would be reduced under the proposal and those making the cost-sharing payments that would otherwise apply.

''(10) OTHER REQUIREMENTS.—Each benefit administrator shall meet such other requirements as the Secretary may specify.

''(e) PHARMACY PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with a benefit administrator to furnish covered prescription medicines and pharmacists' services to enrolled individuals residing in the service area.

''(2) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and requirements:

''(A) LICENSING.—The pharmacy and pharmacists shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

''(B) LIMITATION ON CHARGES.—Pharmacies participating under this part shall not charge an enrolled individual more than the negotiated price for an individual medicine as established under subsection (d)(1), regardless of whether such individual has attained the basic benefit limitation under section 1860B(b)(3), and shall not charge an enrolled individual more than the individual's share of the negotiated price as determined under the provisions of this part.

''(C) PERFORMANCE STANDARDS.—The pharmacy and the pharmacist shall comply with performance standards relating to—

''(i) measures for quality assurance, reduction of medical errors, and participation in the drug utilization review program described in subsection (d)(3)(A);

''(ii) systems to ensure compliance with the confidentiality standards applicable under subsection (d)(5)(A); and

''(iii) other requirements as the Secretary may impose to ensure integrity, efficiency, and the quality of the program.

''(D) DISCLOSURE OF PRICE OF GENERIC MEDICINE.—A pharmacy participating under this part that dispenses a prescription medicine to a medicare beneficiary enrolled under this part shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug that is therapeutically and pharmaceutically equivalent and bioequivalent.

''(f) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG BENEFIT ADMINISTRATORS.—During the period after the Secretary has given notice of intent to terminate a contract with a benefit administrator, the Secretary may transfer responsibilities of the benefit administrator under such contract to another benefit administrator.

''(g) GUARANTEED ACCESS TO MEDICINES IN RURAL AND HARD-TO-SERVE AREAS.—

''(1) IN GENERAL.—The Secretary shall ensure that all beneficiaries have guaranteed access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas, including through the use of incentives such as bonus payments to retail pharmacists in rural areas and extra payments to the benefit administrator for the cost of rapid delivery of pharmaceuticals, and any other actions necessary.

''(2) GAO REPORT.—Not later than 2 years after the implementation of this part the Comptroller General of the United States shall submit to Congress a report on the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in rural and hard-to-serve areas under this part together with any recommendations of the Comptroller General regarding any additional steps the Secretary may need to take to ensure the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in such areas under this part.

''(h) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary is authorized to include in a contract awarded under subsection (c) such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate, including—

''(1) bonus and penalty incentives to encourage administrative efficiency;

''(2) incentives under which benefit administrators share in any benefit savings achieved;

''(3) financial incentives under which savings derived from the substitution of generic medicines in lieu of non-generic medicines are made available to beneficiaries enrolled under this part, benefit administrators,

pharmacies, and the Prescription Medicine Insurance Account; and

''(4) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization.

''INCENTIVE PROGRAM TO ENCOURAGE EMPLOYERS TO CONTINUE COVERAGE

''SEC. 1860H. (a) PROGRAM AUTHORITY.—The Secretary shall develop and implement a program under this section called the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription medicine benefits to retired individuals and to maintain such existing benefit programs, by subsidizing, in part, the cost of providing coverage under qualifying plans.

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

''(1) ASSURANCES.—The sponsor shall—

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

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

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

''(ii) immediately upon determining that the actuarial value of the prescription medicine benefit under the plan falls below the actuarial value of the insurance benefit under this part.

''(2) OTHER REQUIREMENTS.—The sponsor shall provide such information, and comply with such requirements, including information requirements to ensure the integrity of the program, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENT.—

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

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

''(B) was eligible for but was not enrolled in the insurance program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to ⅔ of the monthly premium amount payable from the Prescription Medicine Insurance Account for an enrolled individual, as set for the calendar year pursuant to section 1860D(a)(2).

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

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

''(e) PART D ENROLLMENT FOR INDIVIDUALS WHOSE EMPLOYMENT-BASED RETIREE HEALTH COVERAGE ENDS.—

''(1) ELIGIBLE INDIVIDUALS.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

''(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1860C(a);

''(B) at that time, the individual was covered under a qualified retiree prescription medicine plan for which an incentive payment was paid under this section; and

''(C)(i) the sponsor subsequently ceased to offer such plan; or

''(ii) the value of prescription medicine coverage under such plan became less than the value of the coverage under the program under this part.

''(2) SPECIAL ENROLLMENT PERIOD.—An individual described in paragraph (1) shall be eligible to enroll in the program under this part during the 6-month period beginning on the first day of the month in which—

''(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

''(B) the individual received notice of the change in benefits (in the circumstance described in paragraph (1)(C)(ii)).

''(f) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

''(3) QUALIFIED RETIREE PRESCRIPTION MEDICINE PLAN.—The term 'qualified retiree prescription medicine plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription medicines whose actuarial value to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

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

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

''APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS

''SEC. 1860I. (a) IN GENERAL.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Medicine Insurance Account, a Government contribution equal to—

''(1) the aggregate premiums payable for a month pursuant to section 1860D(a)(2) by individuals enrolled in the program under this part; plus

''(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers; plus

''(3) the benefits payable by reason of the application of section 1860B(c) (relating to catastrophic benefits).

''(b) APPROPRIATIONS TO COVER INCENTIVES FOR EMPLOYMENT-BASED RETIREE MEDICINE COVERAGE.—There are authorized to be appropriated to the Prescription Medicine Insurance Account from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under section 1860H(c).

''DEFINITIONS

''SEC. 1860J. As used in this part—

''(1) the term 'prescription medicine' means—

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

''(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin; and

''(2) the term 'benefit administrator' means an entity which is providing for the administration of benefits under this part pursuant to 1860G.''.

(b) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO FEDERAL SUPPLEMENTARY HEALTH INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking ''and'' after ''section 201(i)(1)''; and

(ii) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Medicine Insurance Account established by section 1860F'';

(B) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund),'';

(C) in the first sentence of subsection (h), by inserting before the period the following: ''and section 1860D(b)(4) (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund)''; and

(D) in the first sentence of subsection (i)—

(i) by striking ''and'' after ''section 1840(b)(1)''; and

(ii) by inserting before the period the following: '', section 1860D(b)(2) (in which case the payments shall come from the Prescription Medicine Insurance Account in the Supplementary Medical Insurance Trust Fund)''.

(2) PRESCRIPTION MEDICINE OPTION UNDER MEDICARE+CHOICE PLANS.—

(A) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(i) in subsection (a)(1)(A), by striking ''parts A and B'' inserting ''parts A, B, and D''; and

(ii) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(B) VOLUNTARY BENEFICIARY ENROLLMENT FOR MEDICINE COVERAGE.—Section 1852(a)(1)(A) of such Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(C) ACCESS TO SERVICES.—Section 1852(d)(1) of such Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

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

''(F) the plan for prescription medicine benefits under part D guarantees coverage of any specifically named covered prescription

medicine for an enrollee, when prescribed by a physician in accordance with the provisions of such part, regardless of whether such medicine would otherwise be covered under an applicable formulary or discount arrangement.''.

(D) PAYMENTS TO ORGANIZATIONS.—Section 1853(a)(1)(A) of such Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(i) by inserting ''determined separately for benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(ii) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(iii) by inserting before the last sentence the following: ''In the case of the payments for benefits under part D, such payment shall initially be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate. By 2006, the adjustments would be for the same risk factors applicable for benefits under parts A and B.''.

(E) CALCULATION OF ANNUAL MEDICARE +CHOICE CAPITATION RATES.—Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate'';

(ii) in paragraph (6)(A), by striking ''rate of growth in expenditures under this title'' and inserting ''rate of growth in expenditures for benefits available under parts A and B''; and

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

''(8) PAYMENT FOR PRESCRIPTION MEDICINES.—The Secretary shall determine a capitation rate for prescription medicines—

''(A) dispensed in 2003, which is based on the projected national per capita costs for prescription medicine benefits under part D and associated claims processing costs for beneficiaries under the original medicare fee-for-service program; and

''(B) dispensed in each subsequent year, which shall be equal to the rate for the previous year updated by the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for prescription medicines for an individual enrolled under part D.''.

(F) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of such Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PROVISION OF PART D BENEFITS.—In no event may a Medicare+Choice organization include as part of a plan for prescription medicine benefits under part D the following requirements:

''(A) NO DEDUCTIBLE; NO COINSURANCE GREATER THAN 50 PERCENT.—A requirement that an enrollee pay a deductible, or a coinsurance percentage that exceeds 50 percent.

''(B) MANDATORY INCLUSION OF CATASTROPHIC BENEFIT.—A requirement that the catastrophic benefit level under the plan be greater than such level established under section 1860B(c).''.

(G) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of such Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for benefits under parts A and B and for prescription medicine benefits under part D.''.

(H) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d) of such Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(6) AVAILABILITY OF NEGOTIATED PRICES.—Each contract under this section shall provide that enrollees who exhaust prescription medicine benefits under the plan will continue to have access to prescription medicines at negotiated prices equivalent to the total combined cost of such medicines to the plan and the enrollee prior to such exhaustion of benefits.''.

(3) EXCLUSIONS FROM COVERAGE.—

(A) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(B) PRESCRIPTION MEDICINES NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

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

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

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

''(J) in the case of prescription medicines covered under part D, which are not prescribed in accordance with such part;''.

SEC. 102. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION MEDICINE COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION TO BUY-IN DUALLY ELIGIBLE INDIVIDUALS.—

(1) COVERAGE OF PREMIUMS AS MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d) is amended in the second sentence of the flush matter at the end by striking ''premiums under part B'' the first place it appears and inserting ''premiums under parts B and D''.

(2) STATE COMMITMENT TO CONTINUE PARTICIPATION IN PART D AFTER BENEFIT LIMIT EXCEEDED.—Section 1902(a) of such Act (42 U.S.C. 1396a) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65)(B) and inserting ''; and''; and

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

''(66) provide that in the case of any individual whose eligibility for medical assistance is not limited to medicare or medicare medicine cost-sharing and for whom the State elects to pay premiums under part D of title XVIII pursuant to section 1860E, the State will purchase all prescription medicines for such individual in accordance with the provisions of such part D, without regard to whether the basic benefit limitation for such individual under section 1860B(b)(3) has been reached.''.

(b) GOVERNMENT PAYMENT OF MEDICARE MEDICINE COST-SHARING REQUIRED FOR QUALIFIED MEDICARE BENEFICIARIES.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

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

''(iii) premiums under section 1860D.''; and

(2) in subparagraph (D)—

(A) by inserting ''(i)'' after ''(D)''; and

(B) by adding at the end the following:

''(ii) PART D COST-SHARING.—The difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).''.

(c) GOVERNMENT PAYMENT OF MEDICARE MEDICINE COST-SHARING REQUIRED FOR MEDICARE BENEFICIARIES WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

(1) STATE PLAN REQUIREMENT.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end; and

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

''(v) for making medical assistance available for medicare medicine cost-sharing (as defined in section 1905(x)(2)) for qualified medicare medicine beneficiaries described in section 1905(x)(1); and''.

(2) 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE MEDICINE COST-SHARING.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

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

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

''(7) except in the case of amounts expended for an individual whose eligibility for medical assistance is not limited to medicare or medicare medicine cost-sharing, an amount equal to 100 percent of amounts as expended as medicare medicine cost-sharing for qualified medicare medicine beneficiaries (as defined in section 1905(x)); plus''.

(3) ADDITIONAL FUNDS FOR MEDICARE MEDICINE COST-SHARING IN TERRITORIES.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), by striking ''subsection (g),'' and inserting ''subsections (g) and (h)''; and

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

''(h) ADDITIONAL MEDICAID PAYMENTS TO TERRITORIES FOR MEDICARE MEDICINE COST-SHARING.—

''(1) IN GENERAL.—In the case of a territory that develops and implements a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under subsection (f) (as increased under subsection (g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of some or all medicare medicine cost sharing (as defined in section 1905(x)(2)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in subsection (g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2003, is equal to $25,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860B(b)(3)(B) for the year involved.''.

(4) DEFINITIONS OF ELIGIBLE BENEFICIARIES AND COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by

adding at the end the following new subsection:

''(x)(1) The term 'qualified medicare medicine beneficiary' means an individual—

''(A) who is enrolled or enrolling under part D of title XVIII;

''(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as referred to in subsection (p)(2)) applicable to a family of the size involved; and

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

''(2) The term 'medicare medicine cost-sharing' means the following costs incurred with respect to a qualified medicare medicine beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

''(A) In the case of a qualified medicare medicine beneficiary whose income (as determined under paragraph (1)) is less than 135 percent of the official poverty line—

''(i) premiums under section 1860D; and

''(ii) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).

''(B) In the case of a qualified medicare medicine beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage of premiums under section 1860D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

''(3) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.''.

(d) MEDICAID MEDICINE PRICE REBATES UNAVAILABLE WITH RESPECT TO MEDICINES PURCHASED THROUGH MEDICARE BUY-IN.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) MEDICINES PURCHASED THROUGH MEDICARE BUY-IN.—The provisions of this section shall not apply to prescription medicines purchased under part D of title XVIII pursuant to an agreement with the Secretary under section 1860E (including any medicines so purchased after the limit under section 1860B(b)(3) has been exceeded).''.

(e) AMENDMENTS TO MEDICARE PART D.—Part D of title XVIII of the Social Security Act (as added by section 2) is amended by inserting after section 1860D the following new section:

''SPECIAL ELIGIBILITY, ENROLLMENT, AND COPAYMENT RULES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860E. (a) STATE OPTIONS FOR COVERAGE: CONTINUATION OF MEDICAID COVERAGE OR ENROLLMENT UNDER THIS PART.—

''(1) IN GENERAL.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual has previously declined the opportunity to enroll in such program.

''(2) ELIGIBILITY GROUPS.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1860C(a) and who are—

''(A) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

''(B) qualified medicare medicine beneficiaries (as defined in section 1905(x)(1)).

''(3) COVERAGE PERIOD.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

''(A) INDIVIDUALS ELIGIBLE (AT STATE OPTION) FOR PART B BUY-IN.—In the case of an individual described in subsection (a)(2)(A), the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

''(B) QUALIFIED MEDICARE MEDICINE BENEFICIARIES.—In the case of an individual described in subsection (a)(2)(B)—

''(i) the coverage period shall begin on the latest of—

''(I) January 1, 2003;

''(II) the first day of the third month following the month in which the State agreement is entered into; or

''(III) the first day of the first month following the month in which the individual satisfies section 1860C(a); and

''(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare medicine cost-sharing.

''(4) ENROLLMENT FOR LOW-INCOME SUBSIDY THROUGH OTHER MEANS.—

''(A) FLEXIBILITY IN ENROLLMENT PROCESS.—With respect to low-income individuals residing in a State enrolling under this part on or after January 1, 2006, the Secretary shall provide for determinations of whether the individual is eligible for a subsidy and the amount of such individual's income to be made under arrangements with appropriate entities other than State medicaid agencies.

''(B) USE OF CERTAIN INFORMATION.—Arrangements with entities under subparagraph (A) shall provide for —

''(i) the use of existing Federal government databases to identify eligibility; and

''(ii) the use of information obtained under section 154 of the Social Security Act Amendments of 1994 for newly eligible medicare beneficiaries, and the application of such information with respect to other medicare beneficiaries.

''(b) SPECIAL PART D ENROLLMENT OPPORTUNITY FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In the case of an individual who—

''(1) satisfies section 1860C(a); and

''(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled under such plan or having been determined eligible for such benefits;

the Secretary shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'State' has the meaning given such term under section 1101(a) for purposes of title XIX.''.

(f) REMOVAL OF SUNSET DATE FOR COST-SHARING IN MEDICARE PART B PREMIUMS FOR CERTAIN QUALIFYING INDIVIDUALS.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv))is amended to read as follows—

''(iv) subject to section 1905(p)(4), for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

(2) RELOCATION OF PROVISION REQUIRING 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR CERTAIN QUALIFYING INDIVIDUALS.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by subsection (c)(3), is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) an amount equal to 100 percent of amounts expended as medicare cost-sharing described in section 1903(a)(10)(E)(iv) for individuals described in such section; plus''.

(3) REPEAL OF SECTION 1933.—Section 1933 is repealed.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2003.

SEC. 103. GAO ONGOING STUDIES AND REPORTS ON PROGRAM; MISCELLANEOUS REPORTS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the prescription medicine benefit program under part D of the Medicare program under title XVIII of the Social Security Act (as added by section 3 of this Act), including an analysis of each of the following:

(1) The extent to which the administering entities have –achieved volume-based discounts similar to the favored –price paid by other large purchasers.

(2) Whether access to the benefits under such program are in fact available to all beneficiaries, with special attention given to access for beneficiaries living in rural and hard-to-serve areas.

(3) The success of such program in reducing medication error and adverse medicine reactions and improving quality of care, and whether it is probable that the program has resulted in savings through reduced hospitalizations and morbidity due to medication errors and adverse medicine reactions.

(4) Whether patient medical record confidentiality is being maintained and safeguarded.

(5) Such other issues as the Comptroller General may consider.

(b) REPORTS.—The Comptroller General shall issue such reports on the results of the ongoing study described in (a) as the Comptroller General shall deem appropriate and shall notify Congress on a timely basis of significant problems in the operation of the part D prescription medicine program and the need for legislative adjustments and improvements.

(c) MISCELLANEOUS STUDIES AND REPORTS.—

(1) STUDY ON METHODS TO ENCOURAGE ADDITIONAL RESEARCH ON BREAKTHROUGH PHARMACEUTICALS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall seek the advice of the Secretary of the Treasury on possible tax and trade law changes to encourage increased original research on new pharmaceutical breakthrough products designed to address disease and illness.

(B) REPORT.—Not later than January 1, 2003, the Secretary shall submit to Congress

a report on such study. The report shall include recommended methods to encourage the pharmaceutical industry to devote more resources to research and development of new covered products than it devotes to overhead expenses.

(2) STUDY ON PHARMACEUTICAL SALES PRACTICES AND IMPACT ON COSTS AND QUALITY OF CARE.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study on the methods used by the pharmaceutical industry to advertise and sell to consumers and educate and sell to providers.

(B) REPORT.—Not later than January 1, 2003, the Secretary shall submit to Congress a report on such study. The report shall include the estimated direct and indirect costs of the sales methods used, the quality of the information conveyed, and whether such sales efforts leads (or could lead) to inappropriate prescribing. Such report may include legislative and regulatory recommendations to encourage more appropriate education and prescribing practices.

(3) STUDY ON COST OF PHARMACEUTICAL RESEARCH.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study on the costs of, and needs for, the pharmaceutical research and the role that the taxpayer provides in encouraging such research.

(B) REPORT.—Not later than January 1, 2003, the Secretary shall submit to Congress a report on such study. The report shall include a description of the full-range of taxpayer-assisted programs impacting pharmaceutical research, including tax, trade, government research, and regulatory assistance. The report may also include legislative and regulatory recommendations that are designed to ensure that the taxpayer's investment in pharmaceutical research results in the availability of pharmaceuticals at reasonable prices.

(4) REPORT ON PHARMACEUTICAL PRICES IN MAJOR FOREIGN NATIONS.—Not later than January 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report on the retail price of major pharmaceutical products in various developed nations, compared to prices for the same or similar products in the United States. The report shall include a description of the principal reasons for any price differences that may exist.

TITLE II—IMPROVEMENT IN BENEFICIARY SERVICES

Subtitle A—Improvement of Medicare Coverage and Appeals Process

SEC. 201. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended to read as follows:

''DETERMINATIONS; APPEALS

''SEC. 1869. (a) INITIAL DETERMINATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

''(1) The initial determination of whether an individual is entitled to benefits under such parts.

''(2) The initial determination of the amount of benefits available to the individual under such parts.

''(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

''(b) APPEAL RIGHTS.—

''(1) IN GENERAL.—

''(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

''(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

''(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

''(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

''(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

''(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

''(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

''(D) TIME LIMITS FOR APPEALS.—

''(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described subparagraph (A) files notice with the Secretary to request reconsideration by not later than 180 days after the individual receives notice of the initial determination under subsection (a) or within such additional time as the Secretary may allow.

''(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

''(E) AMOUNTS IN CONTROVERSY.—

''(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

''(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow 2 or more appeals to be aggregated if the appeals involve—

''(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

''(II) common issues of law and fact arising from services furnished to 2 or more individuals by one or more providers of services or suppliers.

''(F) EXPEDITED PROCEEDINGS.—

''(i) EXPEDITED DETERMINATION.—In the case of an individual who—

''(I) has received notice by a provider of services that the provider of services plans to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

''(II) has received notice by a provider of services that the provider of services plans to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

''(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

''(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

''(2) REVIEW OF COVERAGE DETERMINATIONS.—

''(A) NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

''(I) Such a determination shall not be reviewed by any administrative law judge.

''(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

''(III) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(IV) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(ii) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Secretary respecting whether or not a particular item or service is covered nationally under this title, including such a determination under 1862(a)(1).

''(B) LOCAL COVERAGE DETERMINATION.—In the case of a local coverage determination made by a fiscal intermediary or a carrier

under part A or part B respecting whether a particular type or class of items or services is covered under such parts, the following limitations apply:

''(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(ii) Such a determination may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(C) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of review of a determination under subparagraph (A)(i)(III) or (B)(i) where the moving party alleges that there are no material issues of fact in dispute, and alleges that the only issue is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction.

''(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

''(I) Issue a national coverage determination, with or without limitations.

''(II) Issue a national noncoverage determination.

''(III) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

''(IV) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

''(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

''(iii) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

''(E) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations.

''(ii) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

''(3) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

''(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

''(5) STANDING.—An action under this section seeking review of a coverage determination (with respect to items and services under this title) may be initiated only by one (or more) of the following aggrieved persons, or classes of persons:

''(A) Individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

''(B) Persons, or classes of persons, who make, manufacture, offer, supply, make available, or provide such items and services.

''(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under paragraphs (2) and (3) of subsection (a). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

''(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term 'qualified independent contractor' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a), and that meets the requirements established by the Secretary consistent with paragraph (3).

''(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the following requirements:

''(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required under regulations of the Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

''(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

''(i) such payment is allowed by reason of section 1879;

''(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

''(iii) such determination is changed as the result of any hearing by the Secretary or judicial review of the decision under this section; or

''(iv) such payment is authorized under section 1861(v)(1)(G).

''(C) DEADLINES FOR DECISIONS.—

''(i) DETERMINATIONS.—The qualified independent contractor shall conduct and conclude a determination under subparagraph (B) or an appeal of an initial determination, and mail the notice of the decision by not later than the end of the 45-day period beginning on the date a request for reconsideration has been timely filed.

''(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i), the party requesting the reconsideration or appeal may request a hearing before an administrative law judge, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

''(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or in accordance with the following:

''(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j), not later than 1 day after the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

''(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

''(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

''(i) PHYSICIANS.—No physician under the employ of a qualified independent contractor may review—

''(I) determinations regarding health care services furnished to a patient if the physician was directly responsible for furnishing such services; or

''(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the physician's family has,

directly or indirectly, a significant financial interest in such institution, organization, or agency.

''(ii) PHYSICIAN'S FAMILY DESCRIBED.—For purposes of this paragraph, a physician's family includes the physician's spouse (other than a spouse who is legally separated from the physician under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents.

''(E) EXPLANATION OF DETERMINATIONS.—Any determination of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the determination as well as a discussion of the pertinent facts and applicable regulations applied in making such determination.

''(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

''(G) DISSEMINATION OF INFORMATION.—Each qualified independent contractor shall, using the methodology established by the Secretary under subsection (d)(4), make available all determinations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, and other entities under contract with the Secretary to make initial determinations under part A or part B or title XI.

''(H) ENSURING CONSISTENCY IN DETERMINATIONS.—Each qualified independent contractor shall monitor its determinations to ensure the consistency of its determinations with respect to requests for reconsideration of similar or related matters.

''(I) DATA COLLECTION.—

''(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

''(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

''(I) Specific claims that give rise to appeals.

''(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

''(III) Situations suggesting the need for changes in national or local coverage policy.

''(IV) Situations suggesting the need for changes in local medical review policies.

''(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

''(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the Secretary for a hearing, including as necessary, explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

''(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

''(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

''(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

''(A) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall promulgate regulations governing the processes of reconsiderations of determinations by the Secretary and qualified independent contractors and of hearings by the Secretary. Such regulations shall include such specific criteria and provide such guidance as required to ensure the adequate functioning of the reconsiderations and hearings processes and to ensure consistency in such processes.

''(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

''(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

''(I) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

''(II) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subclause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

''(ii) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (B) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

''(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

''(iv) DAB HEARING PROCEDURE.—In the case of a request described in clause (iii), the Departmental Appeals Board shall review the case de novo.

''(C) POLICIES.—The Secretary shall provide such specific criteria and guidance, including all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

''(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

''(E) EFFECT OF FAILURE TO PUBLISH POLICIES.—

''(i) NATIONAL AND LOCAL COVERAGE POLICIES.—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

''(ii) OTHER POLICIES.—With respect to policies established by the Secretary other than the policies described in clause (i), qualified independent contractors shall not be bound by such policies if the Secretary does not furnish to the qualified independent contractor the policies in a published format consistent with subparagraph (C).

''(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—

''(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

''(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and, in consultation with the Commissioner of Social Security, administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight may not be delegated to regional offices of the Department.

''(4) DISSEMINATION OF DETERMINATIONS.—The Secretary shall establish a methodology under which qualified independent contractors shall carry out subsection (c)(3)(G).

''(5) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with

respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

''(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.''.

(b) APPLICABILITY OF REQUIREMENTS AND LIMITATIONS ON LIABILITY OF QUALIFIED INDEPENDENT CONTRACTORS TO MEDICARE+CHOICE INDEPENDENT APPEALS CONTRACTORS.—Section 1852(g)(4) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at the end the following: ''The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.''.

(c) CONFORMING AMENDMENT TO REVIEW BY THE PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g)) is amended by adding at the end the following new paragraph:

''(3) Findings described in paragraph (1) and determinations and other decisions described in paragraph (2) may be reviewed or appealed under section 1869.''.

SEC. 202. PROVISIONS WITH RESPECT TO LIMITATIONS ON LIABILITY OF BENEFICIARIES.

(a) EXPANSION OF LIMITATION OF LIABILITY PROTECTION FOR BENEFICIARIES WITH RESPECT TO MEDICARE CLAIMS NOT PAID OR PAID INCORRECTLY.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsections:

''(i) Notwithstanding any other provision of this Act, an individual who is entitled to benefits under this title and is furnished a service or item is not liable for repayment to the Secretary of amounts with respect to such benefits—

''(1) subject to paragraph (2), in the case of a claim for such item or service that is incorrectly paid by the Secretary; and

''(2) in the case of payments made to the individual by the Secretary with respect to any claim under paragraph (1), the individual shall be liable for repayment of such amount only up to the amount of payment received by the individual from the Secretary.

''(j)(1) An individual who is entitled to benefits under this title and is furnished a service or item is not liable for payment of amounts with respect to such benefits in the following cases:

''(A) In the case of a benefit for which an initial determination has not been made by the Secretary under subsection (a) whether payment may be made under this title for such benefit.

''(B) In the case of a claim for such item or service that is—

''(i) improperly submitted by the provider of services or supplier; or

''(ii) rejected by an entity under contract with the Secretary to review or pay claims for services and items furnished under this title, including an entity under contract with the Secretary under section 1857.

''(2) The limitation on liability under paragraph (1) shall not apply if the individual signs a waiver provided by the Secretary under subsection (l) of protections under this paragraph, except that any such waiver shall not apply in the case of a denial of a claim for noncompliance with applicable regulations or procedures under this title or title XI.

''(k) An individual who is entitled to benefits under this title and is furnished services by a provider of services is not liable for payment of amounts with respect to such services prior to noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), unless the following conditions are met:

''(1) The provider of services shall furnish a notice of discharge and appeal rights established by the Secretary under subsection (l) to each individual entitled to benefits under this title to whom such provider of services furnishes services, upon admission of the individual to the provider of services and upon notice of determination to discharge the individual from the provider of services, of the individual's limitations of liability under this section and rights of appeal under section 1869.

''(2) If the individual, prior to discharge from the provider of services, appeals the determination to discharge under section 1869 not later than noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), the provider of services shall, by the close of business of such first working day, provide to the Secretary (or qualified independent contractor under section 1869, as determined by the Secretary) the records required to review the determination.

''(l) The Secretary shall develop appropriate standard forms for individuals entitled to benefits under this title to waive limitation of liability protections under subsection (j) and to receive notice of discharge and appeal rights under subsection (k). The forms developed by the Secretary under this subsection shall clearly and in plain language inform such individuals of their limitations on liability, their rights under section 1869(a) to obtain an initial determination by the Secretary of whether payment may be made under part A or part B for such benefit, and their rights of appeal under section 1869(b), and shall inform such individuals that they may obtain further information or file an appeal of the determination by use of the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) maintained by the Secretary. The forms developed by the Secretary under this subsection shall be the only manner in which such individuals may waive such protections under this title or title XI.

''(m) An individual who is entitled to benefits under this title and is furnished an item or service is not liable for payment of cost sharing amounts of more than $50 with respect to such benefits unless the individual has been informed in advance of being furnished the item or service of the estimated amount of the cost sharing for the item or service using a standard form established by the Secretary.''.

(2) CONFORMING AMENDMENT.—Section 1870(a) of the Social Security Act (42 U.S.C. 1395gg(a)) is amended by striking ''Any payment under this title'' and inserting ''Except as provided in section 1879(i), any payment under this title''.

(b) INCLUSION OF BENEFICIARY LIABILITY INFORMATION IN EXPLANATION OF MEDICARE BENEFITS.—Section 1806(a) of the Social Security Act (42 U.S.C. 1395b–7(a)) is amended—

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

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) lists with respect to each item or service furnished the amount of the individual's liability for payment;'';

(4) in paragraph (3), as so redesignated, by striking the period at the end and inserting ''; and''; and

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

''(4) includes the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) for information and questions concerning the statement, liability of the individual for payment, and appeal rights.''.

SEC. 203. WAIVERS OF LIABILITY FOR COST SHARING AMOUNTS.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amended by striking clauses (i) through (iii) and inserting the following:

''(i) the waiver is offered as a part of a supplemental insurance policy or retiree health plan;

''(ii) the waiver is not offered as part of any advertisement or solicitation, other than in conjunction with a policy or plan described in clause (i);

''(iii) the person waives the coinsurance and deductible amount after the beneficiary informs the person that payment of the coinsurance or deductible amount would pose a financial hardship for the individual; or

''(iv) the person determines that the coinsurance and deductible amount would not justify the costs of collection.''.

(b) CONFORMING AMENDMENT.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) In this section, the term 'remuneration' includes the meaning given such term in section 1128A(i)(6).''.

Subtitle B—Establishment of Medicare Ombudsman

SEC. 211. Establishment of Medicare Ombudsman for Beneficiary Assistance and Advocacy.

(a) IN GENERAL.—Within the Health Care Financing Administration of the Department of Health and Human Services, there shall be a Medicare Ombudsman, appointed by the Secretary of Health and Human Services from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subsection (b).

(b) DUTIES.—The Medicare Ombudsman shall—

(1) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

(A) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, a benefit administrator responsible for administering the prescription medicine benefit program under part D of title XVIII of the Social Security Act, or the Secretary;

(B) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C of title XVIII of such Act or a benefit administrator responsible for administering such prescription medicine benefit program; and

(C) submit annual reports to Congress and the Secretary, and include in such reports recommendations for improvement in the administration of this title as the Medicare Ombudsman determines appropriate.

(c) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State-

and community-based consumer organizations, to—

(1) provide information about the medicare program; and

(2) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

(d) DEFINITIONS.—In this section:

(1) The term ''medicare beneficiary'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both.

(2) The term ''medicare program'' means the insurance program established under title XVIII of the Social Security Act.

(3) The term ''fiscal intermediary'' has the meaning given such term under section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a)).

(4) The term ''carrier'' has the meaning given such term under section 1842(f) of the Social Security Act (42 U.S.C. 1395u(f)).

(5) The term ''Medicare+Choice organization'' has the meaning given such term under section 1859(a)(1) of the Social Security Act (42 U.S.C. 1395w–29(a)(1)).

(6) The term ''Secretary'' means the Secretary of Health and Human Services.

TITLE III—MEDICARE+CHOICE REFORMS; PRESERVATION OF MEDICARE PART B DRUG BENEFIT

Subtitle A—Medicare+Choice Reforms

SEC. 301. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0 percentage points''.

SEC. 302. PERMANENTLY REMOVING APPLICATION OF BUDGET NEUTRALITY BEGINNING IN 2002.

Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), in the matter following clause (ii), by inserting ''(for years before 2002)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(before 2002)'' after ''for each year''.

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853(c)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is amended—

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

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

''(II) For 2002 for any of the 50 States and the District of Columbia, $450.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to years beginning with 2002.

SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

(a) IN GENERAL.—Section 1853(c)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking ''(ii) For a subsequent year'' and inserting ''(ii)(I) Subject to subclause (II), for a subsequent year''; and

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

''(II) During 2002, 2003, 2004, and 2005, in the case of a Medicare+Choice payment area in which there is no more than 1 contract entered into under this part as of July 1 before the beginning of the year, 102.5 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(b) CONSTRUCTION.—The amendments made by subsection (a) do not affect the payment of a first time bonus under section 1853(i) of the Social Security Act (42 U.S.C. 1395w–23(i)).

SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN CERTAIN MEDICARE+CHOICE PAYMENT AREAS BELOW NATIONAL AVERAGE.

Section 1853(c)(1) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(1) in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''; and

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

''(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

''(i) IN GENERAL.—For each year beginning with 2004, in the case of a Medicare+Choice payment area for which the Medicare+Choice capitation rate under this paragraph would otherwise be less than the United States per capita cost (USPCC), as calculated by the Secretary, a Medicare+Choice organization may negotiate with the Medicare Benefits Administrator an annual per capita rate that—

''(I) reflects an annual rate of increase up to the rate of increase specified in clause (ii);

''(II) takes into account audited current data supplied by the organization on its adjusted community rate (as defined in section 1854(f)(3)); and

''(III) does not exceed the United States per capita cost, as projected by the Secretary for the year involved.

''(ii) MAXIMUM RATE DESCRIBED.—The rate of increase specified in this clause for a year is the rate of inflation in private health insurance for the year involved, as projected by the Medicare Benefits Administrator, and includes such adjustments as may be necessary—

''(I) to reflect the demographic characteristics in the population under this title; and

''(II) to eliminate the costs of prescription drugs.

''(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.''.

SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED ON DATA FROM ALL SETTINGS.

Section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

''and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the methodology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.''.

Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including injectable and infusable drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

SEC. 312. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) REVISION OF MEDICARE COVERAGE FOR IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) (as amended by section 227(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1832 of the Social Security Act (42 U.S.C. 1395k) (as amended by section 227(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

(B) Subsections (c) and (d) of section 227 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–355), as enacted into law by section 1000(a)(6) of Public Law 106–113, are repealed.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs furnished on or after October 1, 2001.

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after October 1, 2001, this subparagraph shall be applied without regard to any time limitation.''.

(c) ESTABLISHMENT OF PART D CATASTROPHIC LIMIT ON PART B COPAYMENTS FOR IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

''(p) LIMITATION ON AMOUNT OF DEDUCTIBLES AND COINSURANCE FOR IMMUNOSUPPRESSIVE DRUGS FOR CERTAIN BENEFICIARIES.—With respect to 2006 and each subsequent year, no deductibles and coinsurance applicable to immunosuppressive drugs (as described in section 1861(s)(2)(J)) in a year under this part shall be imposed to the extent that the individual has incurred expenditures in that year for out-of-pocket expenditures for such immunosuppressive drugs in excess of the catastrophic benefit level specified in section 1860B(c).''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to drugs furnished on or after October 1, 2001.

Subtitle C—Improvement of Certain Preventive Benefits

SEC. 321. COVERAGE OF ANNUAL SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) IN GENERAL.—

(1) ANNUAL SCREENING PAP SMEAR.—Section 1861(nn)(1) of the Social Security Act (42 U.S.C. 1395x(nn)(1)) is amended by striking ''if the individual involved has not had such a test during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3).'' and inserting ''if the woman involved has not had such a test during the preceding year.''.

(2) ANNUAL SCREENING PELVIC EXAM.—Section 1861(nn)(2) of such Act (42 U.S.C. 1395x(nn)(2)) is amended by striking ''during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3),'' and inserting ''during the preceding year,''.

(3) CONFORMING AMENDMENT.—Section 1861(nn) of such Act (42 U.S.C. 1395x(nn)) is amended by striking paragraph (3).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to items and services furnished on or after January 1, 2006.

Amend the title so as to read: ''A Bill to amend title XVIII of the Social Security Act to provide a prescription medicine benefit under the medicare program, to enhance the preventive benefits covered under such program, and for other purposes.''

TITLE IV—ADJUSTMENTS TO PAYMENT PROVISIONS OF THE BALANCED BUDGET ACT

Subtitle A—Payments for Inpatient Hospital Services

SEC. 401. ELIMINATING REDUCTION IN HOSPITAL MARKET BASKET UPDATE FOR FISCAL YEAR 2001.

Section 1886(b)(3)(B)(i)(XVI) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XVI)) is amended by striking ''minus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals,'' and inserting ''for hospitals in all areas,''.

SEC. 402. ELIMINATING FURTHER REDUCTIONS IN INDIRECT MEDICAL EDUCATION (IME) FOR FISCAL YEAR 2001.

Section 1886(d)(5)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)) is amended—

(1) in subclause (IV)—

(A) by striking ''fiscal year 2000'' and inserting ''each of fiscal years 2000 and 2001''; and

(B) by adding ''and'' at the end;

(2) by striking subclause (V); and

(3) by redesignating subclause (VI) as subclause (V).

SEC. 403. ELIMINATING FURTHER REDUCTIONS IN DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) MEDICARE PAYMENTS.—Section 1886(d)(5)(F)(ix) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

(1) in subclause (III), by striking ''and 2001'';

(2) by redesignating subclauses (IV) and (V) as subclauses (V) and (VI), respectively; and

(3) by inserting after subclause (III) the following new subclause:

''(IV) during fiscal year 2001, such additional payment amount shall be reduced by 0 percent;''.

(b) FREEZE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEAR 2001.—Notwithstanding section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r–4(f)(2)), the DSH allotment under such section for a State for fiscal year 2001 shall be the same as the DSH allotment under such section for fiscal year 2000.

SEC. 404. INCREASE BASE PAYMENT TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in clause (i), by striking ''October 1, 1997, 50 percent ('' and inserting ''October 1, 2000, 25 percent (for discharges between October 1, 1997 and September 30, 2000, 50 percent,''; and

(2) in clause (ii), in the matter preceding subclause (I), by striking ''after October 1, 1997, 50 percent ('' and inserting ''after October 1, 2000, 75 percent (for discharges between October 1, 1997, and September 30, 2000, 50 percent,''.

Subtitle B—Payments for Skilled Nursing Services

SEC. 411. ELIMINATING REDUCTION IN SNF MARKET BASKET UPDATE FOR FISCAL YEAR 2001.

Section 1888(e)(4)(E) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)) is amended—

(1) by redesignating subclauses (II) and (III) as subclauses (III) and (IV) respectively;

(2) in subclause (III) as redesignated, by striking ''for each of fiscal years 2001 and 2002,'' and inserting ''for fiscal year 2002,''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) for fiscal year 2001, the rate computed for fiscal year 2000 increased by the skilled nursing facility market basket percentage increase for fiscal year 2000.''.

SEC. 412. EXTENSION OF MORATORIUM ON THERAPY CAPS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended in paragraph (4) by striking ''2000 and 2001.'' and inserting ''2000 through 2002.''.

Subtitle C—Payments for Home Health Services

SEC. 421. 1-YEAR ADDITIONAL DELAY IN APPLICATION OF 15 PERCENT REDUCTION ON PAYMENT LIMITS FOR HOME HEALTH SERVICES.

Section 1895(b)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

(1) by redesignating subparagraph (II) as subparagraph (III);

(2) by inserting in subparagraph (III), as redesignated, ''24 months'' following ''periods beginning''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).''.

SEC. 422. PROVISION OF FULL MARKET BASKET UPDATE FOR HOME HEALTH SERVICES FOR FISCAL YEAR 2001.

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

(1) by striking ''2001,''; and

(2) by adding at the end the following: ''With respect to cost reporting periods beginning during fiscal year 2001, the update to any limit under this subparagraph shall be the home health market basket.''.

Subtitle D—Rural Provider Provisions

SEC. 431. ELIMINATION OF REDUCTION IN HOSPITAL OUTPATIENT MARKET BASKET INCREASE.

Section 1833(t)(3)(C)(iii) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking ''reduced by 1 percentage point for such factor for services furnished in each of 2000, 2001, and 2002'' and inserting ''reduced by 1 percentage point for such factor for services furnished in 2000 and reduced (except in the case of hospitals located in a rural area, as defined for purposes of section 1886(d)) by 1 percentage point for such factor for services furnished in each of 2001 and 2002.''

Subtitle E—Other Providers

SEC. 441. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

The last sentence of section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by striking ''for such services furnished on or after January 1, 2001, by 1.2 percent'' and inserting ''for such services furnished on or after January 1, 2001, by 2.4 percent''.

Subtitle F—Provision for Additional Adjustments

SEC. 451. GUARANTEE OF ADDITIONAL ADJUSTMENTS TO PAYMENTS FOR PROVIDERS FROM BUDGET SURPLUS.

Notwithstanding any other provision of law, from amounts estimated to be in excess social security surpluses estimated under the Balanced Budget and Emergency Deficit Control Act of 1985 for the 5 fiscal year and 10 fiscal year periods beginning in fiscal year 2001, there shall be made available for further adjustments to payment policies established by the Balanced Budget Act of 1997, amounts that would provide for additional improvements to the medicare and medicaid programs carried out under titles XVIII and XIX of the Social Security Act and payments to providers of services and suppliers furnishing items and services for which payments is made under those programs in the aggregate amounts over such 5 fiscal year and 10 fiscal year periods of $11,000,000, and $21,000,000, respectively.

TITLE V—IMPLEMENTATION OF CERTAIN PROVISIONS CONTINGENT ON GUARANTEE OF CERTIFICATION OF TRUST FUND SURPLUSES

SEC. 501. IMPLEMENTATION OF CERTAIN PROVISIONS BEFORE 2005 CONTINGENT ON ENSURING DEBT RETIREMENT AND INTEGRITY OF THE SOCIAL SECURITY AND MEDICARE TRUST FUND SURPLUSES.

(a) IN GENERAL.—Notwithstanding any other provision of this Act, the amendments made by title IV (and catastrophic benefits under section 1860B(c) of the Social Security Act, as inserted by section 101(a)(2)) shall not take apply for a year before 2006 (or, in the case of title IV, a fiscal year before fiscal year 2006), unless the certifications specified by subsection (b) for the fiscal year (or the fiscal year in which the calendar year involved begins) are made before the beginning of such fiscal year.

(b) CERTIFICATIONS SPECIFIED.—The certifications specified in this subsection are the following:

(1) The Director of Office of Management and Budget has certified that a law has been enacted which—

(A) ensures that a sufficient portion of the on-budget surplus is reserved for debt retirement to put the Government on a path to eliminate the publicly held debt by fiscal year 2012 under current economic and technical projections; and

(B) ensures that, under current economic and technical projections, the unified budget surplus for the fiscal year in which such calendar year begins shall not be less than the surplus of the Federal Old-Age and Survivors Insurance Trust Fund and Federal Hospital Insurance Trust Fund for such fiscal year.

(2) The Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund has certified either—

(A) that outlays from such trust funds are not anticipated to exceed the revenues to such trust funds during such fiscal year and any of the next 5 fiscal years; or

(B) that legislation has been enacted extending the solvency of such trust funds for 75 years.

(3) The Board of Trustees of the Federal Hospital Insurance Trust Fund has certified—

(A) that the outlays from such trust fund are not anticipated to exceed the revenues to such trust fund during such fiscal year and any of the next 5 fiscal years; and

(B) that legislation has been enacted which strengthens and modernizes the medicare program and extends the solvency of such trust fund beyond 2030.

Mr. STARK (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the man from California?

There was no objection.

Mr. STARK. Mr. Speaker, I yield 30 seconds to the gentleman from Pennsylvania (Mr. HOEFFEL).

Mr. HOEFFEL. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, what is this House going to say to Earl and Irene Baker, who came to my town hall meeting and told me about the 21 pills that Earl takes every day and how Irene cannot fill her prescription drugs because she figures her husband is sicker than she is and they cannot afford to fill both sets of prescriptions?

I say, do not put them at the mercy of private insurance companies, do not make them write a $39 check each month to pay their premium and keep their coverage. Give them a guaranteed, defined benefit, reliable Medicare prescription drug coverage. They deserve it and they need it.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to explain that this Democratic motion to recommit would give the American people a true Medicare benefit and start us on the road to providing meaningful, adequate protection for seniors.

Mr. Speaker, this is the same bill as was just ruled out of order with some changes to make the benefit to extend the benefits in time so that it fits within the budget requirements. It covers half of all spending on medicines up to $5,000. It has a $25 a month premium and that is deductible.

It will not require our seniors to mail a check for $39 a month to some private insurance company, as would be required under the Republican bill. It has an out-of-pocket limit of $4,000. After the beneficiaries have spent $4,000, all funds above that spent for pharmaceutical prescriptions will be covered.

Our package, in essence, provides twice as much help for our seniors as does the Republican bill.

Mr. Speaker, in our motion to recommit, we use a budget determination safety device. It would provide up to $21 billion over 5 years and $40 billion over 10 years to help health care providers, hospitals, nursing homes, home health agencies, rural hospitals, and others to deal with the unexpected tough cuts in the balanced budget amendment.

It would provide these where there is certification by OMB and we are on a path to retiring the publicly held national public debt by 2012, that Social Security is safe, and that Medicare is solvent past 2030.

Mr. Speaker, our proposal is not the Republicans' let-us-help-you-buy-a-Medigap scheme, it is a benefit in Medicare as to Part A. They go to the doctor, any doctor, Medicare pays the bill. They pay 20 percent of that bill unless they have supplemental insurance or a union plan or they are in a managed care plan, in which case they pay nothing. That is what we do with pharmaceuticals.

□ 2030

They do not shop around from insurance company to insurance company. They can, in our plan, stay with their company plan. They can stay with their HMO. They can stay with whatever they are happy with, or they can voluntarily join the Medicare plan for a premium of $25 a month, $14 a month less than the Republican premium for twice the benefits.

The plan will cover all Medicare beneficiaries, and it will cover 5½ million more beneficiaries, according to the Congressional Budget Office, than the Republican plan.

It helps low-income seniors, and it contains the same relief for rural HMOs as does the Republican bill.

This is a bill that will help the American people, not the drug industry or the insurers. Quite contrarily, it will do nothing for the drug industry or the insurers. It will do something for our seniors who need the help.

This should say, if one likes high-priced pills, support the Republican bill, which is supported by the drug makers' lobby. If they like hassles of HMOs, support the Republican bill. It would force everyone into a drug HMO program where they will be hassled over every pill their doctor prescribes, and they will be forced to drive miles and miles to some distant pharmacy. Under our bill, any pharmacy, any provider, would be able to provide their prescription if they chose to.

If one wants a true, dependable, reliable benefit that covers all Americans who need help, support the Democratic bill and support the motion to recommit.

The SPEAKER pro tempore (Mr. LAHOOD). Does the gentleman from California (Mr. THOMAS) seek the time in opposition?

Mr. THOMAS. I do, Mr. Speaker.

Mr. Speaker, this was an important debate, although at some point the seniors are tired of waiting for Congress to act to put prescription drugs in Medicare. I want all Members to understand the significance of this vote on the motion to recommit. Although it may not seem important, the motion to recommit of the gentleman from California (Mr. STARK) is not forthwith. If the motion were forthwith, the legislation the gentleman described would be substituted for the bipartisan plan, and it would come back in front of the House to be voted upon.

The motion the gentleman offered on the motion to recommit was to report promptly. That means, in reality, that any prescription drug benefit for seniors this year is gone.

I would sober everyone up by saying that if they vote for this motion to recommit, they will have denied the seniors the opportunity that all of us want to provide them with.

The reason there is no point of order against this motion, although over the 10-year period it spends $295 billion, is because, as the gentleman from California said, there is a trigger.

One really ought to examine the trigger that is in this legislation. First of all, it says that there has to be a law that says we are going to retire the entire Federal debt by 2012. We are for that, but this bill adds $300 billion to the job of doing that.

Secondly, it says that there has to be legislation that has been passed guaranteeing the solvency of Social Security for 75 years. We could have already done that.

The chairman of the Committee on Ways and Means, the gentleman from Texas (Mr. ARCHER), and the chairman of the subcommittee, the gentleman from Florida (Mr. SHAW), have legislation ready to go that will not worry about the 75-year provision because it resolves the solvency of Social Security for all time.

If the President had been willing to address that problem, this would not have been in their bill. We would have guaranteed the solvency of Social Security.

There is another trigger that says solvency has to be guaranteed, under law, for the hospital trust fund, Medicare, beyond 2030.

The bipartisan commission that this Congress created could have provided a plan had the President been willing to cooperate with the public and private Members of the House and the Senate, the Democrats and the Republicans who all came together and provided 10 votes for that plan, but not one of the President's appointees agreed with that plan. That would have been met had the President been willing to work with the bipartisan commission.

So what do we have in front of us? A bill that gives no choice, limits choices of drugs. Basic benefits are flat, not just for 2003, 2004 but 2005 as well, and provides no out-of-pocket protection for seniors until the year 2006. Two presidential elections have to go by before seniors are guaranteed that their exposure to drug costs are limited.

The bipartisan plan has freedom to choose. There are a number of drugs in the various classes. The benefits are increased by the drug inflation rate, and one gets immediate pocketbook protection when they vote for H.R. 4680.

I would ask everyone here to make sure that seniors get prescription drugs this year. Vote no on the motion to recommit, and vote yes on the bipartisan H.R. 4680.

Mr. STENHOLM. Mr. Speaker, I rise in strong support of a Medicare prescription drug benefit that is available, affordable, dependable and voluntary for all seniors and against the bill the leadership has brought to the floor today.

The Democratic plan will provide a meaningful prescription benefit that is available to all seniors, including those in rural areas. Unlike H.R. 4680, it will provide equal treatment for all seniors, without disparities in coverage between rural, urban and suburban regions. It will use market power of seniors to reduce costs through competition, and it will help low and middle-income seniors afford prescription medicine.

I am particularly pleased that the Democratic plan contains an amendment I suggested which will ensure that the Medicare prescription drug benefit will fit within a fiscally responsible budget. Specifically, the Democratic plan requires that we stay on a course to take the Medicaid trust fund off budget and eliminate the debt held by the public by 2012. In addition, despite what some of my colleagues on the other side have stated, the Democratic plan would provide a catastrophic benefit in 2003 if Congress and the President work together to enact reforms to strengthen and modernize Medicare. Several supporters of H.R. 4860 have said we need to reform Medicare, but unlike the Democratic plan, H.R. 4860 does not call for action on Medicare reform.

Relying on private sector plans to deliver prescription drug coverage as H.R. 4860 would do will not provide a meaningful benefit which is available to all seniors, including those in rural areas. It will not be cost effective for private plans to offer coverage in rural areas, which will result in expensive government subsidies to attract plans to rural areas. Rural seniors should not be forced to pay higher premiums or have less generous benefits, simply because they live in areas that are not financially attractive to private insurance companies.

I am not hostile to private sector solutions. But we understand the role of the private sector is to make a profit. Meanwhile, the role of the government is to provide benefits in situations of great need that go unanswered by business.

Over the past decade, crop insurance for farmers has shown not only that private insurance sometimes fails to provide a guaranteed safety net in necessary situations, but also that it can become enormously costly. Even though the Republican's prescription drug bill is tallied at $40 billion today, I have no doubt that, just like crop insurance, its costs would multiply many, many time as we have to come back to provide higher and higher subsidies over the coming years, and still seniors would be left without the guarantee of prescription drug coverage.

Seniors deserve certainty about getting help with their prescription drugs. They deserve to be treated equally, regardless of whether they live in rural communities like my District or big cities like Dallas. They deserve to have their government supporting them with their most basic life needs. They deserve to have a Medicare program which is modernized in a way that reassures them the program will be strong for their grandkids. That is what the Democratic motion to recommit would do and what the bill before us fails to do.

Mr. EVANS. Mr. Speaker, over the past few weeks, the Republican leadership in Congress has been scrambling to score political points by pushing a flawed prescription drug bill. But to millions of America's seniors, this is not a political game, but a matter of life or death.

The Republican prescription drug plan is barely a plan at all. It is a sham that favors insurance companies over older Americans and profits over quality care. It fails to provide affordable prescription coverage for all seniors and limits the choices of essential medications and pharmacies.

The so-called plan doesn't even lay out a defined benefits package. Private insurers will be able to establish restrictive formularies and exclude coverage of drugs that they deem too expensive.

The Republicans are offering a benefits package that offers no benefits at all. If we pass this plan, our seniors would be left no better off then they are today. Let's give our seniors the health care they need and deserve. Please support the motion to recommit.

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Mr. DAVIS of Illinois. Mr. Speaker, I rise today in support of the Democratic Alternative to the Republican proposal for a prescription drug benefit for seniors.

As we know, the Medicare program provides significant health insurance coverage for more than 39 million seniors and disabled beneficiaries. However, the program fails to offer protection against the costs of most outpatient prescription drugs. In the 7th District of Illinois, there are 57,353 seniors (65 years and older) who need quality, affordable drug coverage. Patricia Conyers, William Danne, Cassandra Moore, and many others from my district deserve this.

Life-saving and sustaining drugs are just as important to seniors today as surgery and clinical evaluation. For example, cardiovascular disease is the leading cause of death in America. Patients with severe heart failure must take at least 3, often 5, medicines at a time.

Prescription drug prices continue to rise and the percentage of Americans over age 65 is sharply on the rise—as technology improves, it prolongs life. Last year alone, our nation spent $105 billion on prescription drugs. Accordingly to one study, we will spend 15–18% more in the next five years, more than $200 billion each year. This year, more than one-third of seniors on Medicare will spend over $1,000 on prescription medication.

Even worse still are the seniors in our communities who have no drug coverage at all. They are forced to make life-threatening decisions between prescription drugs or food and clothing. These decisions are unfair and un-Democratic. Twenty-seven percent of urban beneficiaries, and 43% of rural beneficiaries lack prescription drug coverage for the entire year (1996).

Clearly, neither Medicare nor the private insurance industry are addressing the problem adequately. Medicare is therefore in need of modernization and the addition of a drug benefit that is accessible and affordable to all beneficiaries, regardless of income level or location. The Democratic Plan would provide a voluntary prescription drug benefit accessible and affordable to all Medicare beneficiaries. This is not a new entitlement program as some Republican colleagues claim; it's simply a long-needed modernization of Medicare.

Regarding accessibility. Our plan guarantees a prescription benefit for all Medicare beneficiaries, whether or not they are rich or poor, enrolled in traditional fee-for-service or Medicare+Choice plans. In our plan, low-income beneficiaries—below 150% poverty level ($17,000 for a couple)—would receive extra help with the cost of premiums; those below 135% would have no cost-sharing.

And regarding affordability: Under the Democratic plan, beneficiaries who join the program receive a high quality, defined benefit. It is affordable to all beneficiaries. Premiums would be $25 per month in 2003. Seniors would pay no yearly deductible. Also, the plan offers catastrophic protection (over $4000 out-of-pocket costs) for beneficiaries. This plan, therefore, protects against the risk of industry ''cherry picking'' and negative selection of seniors with the greatest need.

Finally, the Democratic prescription drug benefit is consistent with broader reform to strengthen and modernize Medicare. This plan includes greater access to the wide array of prescription drugs available in our marketplace by providing affordable premiums to all Medicare beneficiaries. Therefore, I urge all my colleagues to support the Democratic Plan for prescription drug coverage for seniors. This is true reform.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. STARK. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 204, nays 222, not voting 9, as follows:

[Roll No. 356]

YEAS—204

Abercrombie	Andrews	Baldacci
Ackerman	Baca	Baldwin
Allen	Baird	Barcia

Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Forbes
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gonzalez
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (WA)
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NAYS—222

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bateman
Bereuter
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth-Hage
Coble
Coburn
Collins
Combest
Cooksey
Cox
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
King (NY)
Kingston
Kolbe
Kuykendall
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
Martinez
McCollum
McCrery
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Ose
Oxley
Packard
Paul
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Scarborough
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Traficant
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NOT VOTING—9

Bass
Cook
DeGette
Filner
Hooley
Knollenberg
Markey
Serrano
Vento

□ 2052

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated for:

Mr. SERRANO. Mr. Speaker, I was unfortunately detained during rollcall No. 356, and I want the RECORD to reflect that if I had been present, my vote would have been ''yea.''

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. STARK. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 217, nays 214, not voting 4, as follows:

[Roll No. 357]

YEAS—217

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Coble
Collins
Combest
Cooksey
Cox
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Hoekstra
Horn
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
King (NY)
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Maloney (CT)
Manzullo
Martinez
McCollum
McCrery
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Ose
Oxley
Packard
Pease
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Scarborough
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (NJ)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Traficant
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NAYS—214

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Chenoweth-Hage
Clay
Clayton
Clement
Clyburn
Coburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Forbes
Ford
Frank (MA)
Frost
Ganske
Gejdenson
Gephardt
Gonzalez
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hostettler
Hoyer
Inslee
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (NY)
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott

McGovern	Payne	Smith (WA)
McIntyre	Pelosi	Snyder
McKinney	Phelps	Spratt
McNulty	Pickett	Stabenow
Meehan	Pomeroy	Stark
Meek (FL)	Price (NC)	Stenholm
Meeks (NY)	Rahall	Strickland
Menendez	Rangel	Stupak
Millender-McDonald	Reyes	Tanner
	Rivers	Tauscher
Miller, George	Rodriguez	Taylor (MS)
Minge	Roemer	Thompson (CA)
Mink	Rothman	Thompson (MS)
Moakley	Roybal-Allard	Thurman
Mollohan	Rush	Tierney
Moore	Sabo	Towns
Moran (VA)	Sanchez	Turner
Morella	Sanders	Udall (CO)
Murtha	Sandlin	Udall (NM)
Nadler	Sanford	Velazquez
Napolitano	Sawyer	Visclosky
Neal	Schaffer	Waters
Oberstar	Schakowsky	Watt (NC)
Obey	Scott	Waxman
Olver	Serrano	Weiner
Ortiz	Sherman	Wexler
Owens	Shows	Weygand
Pallone	Sisisky	Wise
Pascrell	Skelton	Woolsey
Pastor	Slaughter	Wu
Paul	Smith (MI)	Wynn

NOT VOTING—4

Cook	Markey
Filner	Vento

☐ 2109

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

☐ 2115

PROVIDING FOR CONSIDERATION OF H.R. 4461, AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2001

Mr. DIAZ-BALART. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 538 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 538

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 4461) making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 2001, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations. After general debate the bill shall be considered for amendment under the five-minute rule. When the reading for amendment reaches title VIII, that title shall be considered as read. Points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived except as follows: page 74, line 19, through page 75, line 4; page 84, line 21, through page 96, line 4. During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. The Chairman of the Committee of the Whole may: (1) postpone until a time during further consideration in the Committee of the Whole a request for a recorded vote on any amendment; and (2) reduce to five minutes the minimum time for electronic voting on any postponed question that follows another electronic vote without intervening business, provided that the minimum time for electronic voting on the first in any series of questions shall be 15 minutes. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

SEC. 2. House Resolution 513 is laid on the table.

Mr. DIAZ-BALART. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MOAKLEY), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for purposes of debate only.

Mr. Speaker, House Resolution 538 is an open rule providing for the consideration of H.R. 4461, the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2001.

The rule provides for 1 hour of general debate, equally divided between the chairman and ranking minority member of the Committee on Appropriations. The rule waives all points of order against consideration of the bill. Further, the rule waives points of order against provisions of the bill for failure to comply with clause 2 of rule XXI, except as specified in the rule.

The rule allows the Chairman of the Committee of the Whole to accord priority in recognition to Members who have preprinted their amendments in the CONGRESSIONAL RECORD, and further, it allows the Chairman to postpone votes during consideration of the bill, and to reduce voting time to 5 minutes on a postponed question if the vote follows a 15-minute vote. The rule provides 1 motion to recommit, with or without instructions.

Finally, the rule provides that House Resolution 513 is laid on the table.

Mr. Speaker, I am pleased to support this open rule which provides for the consideration of the agriculture appropriations bill for fiscal year 2001. The primary difference between this rule and the one reported by our committee last month, House Resolution 513, is the removal of the amendment which would have offset funds provided for relief to apple and potato farmers. Due to the reallocation of funds by the Committee on Appropriations, which now keeps this funding within the subcommittee's budget limits, the offset amendment is no longer necessary.

A substantive legislative provision which constitutes a change in current law has been exposed to a point of order by this rule, title VIII of the bill, a provision which would, in my view, undermine U.S. foreign policy goals with regard to terrorist states by eliminating restrictions on the sale of agricultural commodities to the terrorist states, Iran, Libya, Iraq, Cuba, and North Korea.

Mr. Speaker, the reason why the House rules preclude major changes in substantive legislative policy on appropriations bills is that the appropriations process has hearings and is set up for deliberation on appropriations issues, while the authorizing process, the authorizing committees, have hearings on major legislative policy changes, and they are set up to concentrate on and improve major, substantive legislative policy proposals.

I think that an example of why the House has this rule is in fact before us today. My friend, the gentleman from Washington (Mr. NETHERCUTT), included an amendment in the appropriations bill, as I mentioned, to end restrictions on the sale of agricultural commodities to rogue regimes. The legislation allegedly precluded exports from the terrorist states to the United States, and prohibited Federal financing of sales to those States.

After reviewing the legislation carefully, however, the Congressional Research Service, for example, informed my office that that is not necessarily correct. It was not clear, for example, that exports to the United States from the terrorist states would be precluded, and secondly, with regard to Federal financing, at least one significant credit program would have become available to any of those rogue regimes if the administration simply deleted them from the State Department terrorist list; something, by the way, Mr. Speaker, that the administration has admitted it is considering doing with a number of terrorist states, despite the fact that some of these States have recently carried out the murders of United States citizens.

In fact, only last week Secretary of State Albright tinkered with the terminology by declaring that the terrorist states are no longer rogue states, but rather, states of concern. It is obvious that various or all of these terrorist regimes will soon be taken off the terrorist list by the current administration.

I informed my friend, the gentleman from Washington (Mr. NETHERCUTT), of these concerns. But in the appropriations process, we simply cannot amend this legislation pursuant to and after the necessary study to make certain that we are not doing what even the legislation's proponents do not wish to do.

In addition, in my view, the timing of the legislation offered by the gentleman from Washington (Mr. NETHERCUTT) has been unfortunate. We are dealing here with states that have engaged in acts of terrorism against Americans in recent years. We are