

Capitol Building Complex after any person unless not less than 5 years have passed since the death of that person.

(b) DURATION.—

(1) IN GENERAL.—Except as provided under paragraph (2), the naming, by the Senate, of any portion of the Senate wing of the Capitol Building Complex shall remain in force for a period not to exceed 25 years beginning on the date of enactment of the Act or resolution that established such name.

(2) EXISTING NAMED AREAS.—Any portion of the Senate wing of the Capitol Building Complex that is named as of the date of adoption of this resolution shall no longer be so named after the date that is 25 years after the date of adoption of this resolution.

(c) DEFINITION.—In this resolution, the term “Senate wing of the Capitol Building Complex” includes—

- (1) the Senate wing of the United States Capitol Building;
- (2) the Russell Senate Office Building;
- (3) the Dirksen Senate Office Building;
- (4) the Hart Senate Office Building; and
- (5) spaces designated under the control of the Senate in the Capitol Visitor Center.

AMENDMENTS SUBMITTED & PROPOSED

SA 975. Mr. ROCKEFELLER (for himself, Ms. MIKULSKI, and Mrs. CLINTON) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

SA 976. Mr. ROCKEFELLER (for himself, Mr. CARPER, Mr. GRAHAM, of Florida, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DODD) proposed an amendment to the bill S. 1, supra.

SA 977. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 978. Mr. JEFFORDS (for himself, Mr. KERRY, Mr. REID, Mr. DURBIN, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 14, to enhance the energy security of the United States, and for other purposes; which was ordered to lie on the table.

SA 979. Mr. AKAKA (for himself, Mr. SARBANES, and Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

SA 980. Mr. AKAKA proposed an amendment to the bill S. 1, supra.

SA 981. Mr. PRYOR proposed an amendment to the bill S. 1, supra.

SA 982. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 983. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 984. Mr. BINGAMAN proposed an amendment to the bill S. 1, supra.

SA 985. Mr. BAUCUS (for Mr. EDWARDS (for himself and Mr. HARKIN)) proposed an amendment to the bill S. 1, supra.

SA 986. Mr. BAUCUS (for Mr. LAUTENBERG (for himself, Mr. REED, Mrs. CLINTON, and Mr. CORZINE)) proposed an amendment to the bill S. 1, supra.

SA 987. Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr. DURBIN, Mr. KERRY, Mr. TALENT, Mr. REED, Mrs. MURRAY, Mr. SPECTER, Mrs. FEINSTEIN, Mr. CORZINE, Mr. BIDEN, Mr. BOND, and Mr. SCHUMER) submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 988. Mr. THOMAS (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 989. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 990. Mrs. MURRAY proposed an amendment to the bill S. 1, supra.

SA 991. Mr. HARKIN proposed an amendment to the bill S. 1, supra.

SA 992. Mr. BAUCUS (for Ms. STABENOW (for himself and Ms. SNOWE)) proposed an amendment to the bill S. 1, supra.

SA 993. Mr. BAUCUS (for Mr. DORGAN) proposed an amendment to the bill S. 1, supra.

SA 994. Mr. DURBIN (for himself, Mr. CORZINE, Mr. HARKIN, Mrs. BOXER, Ms. STABENOW, Mr. DAYTON, and Mr. BYRD) proposed an amendment to the bill S. 1, supra.

SA 995. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 996. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 997. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 998. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 999. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1000. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 975. Mr. ROCKEFELLER (for himself, Ms. MIKULSKI, and Mrs. CLINTON) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 10, lines 12 and 13, strike “(other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E))”.

On page 21, strike lines 22 through 25, and insert “title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.”

On page 107, line 3, strike “30 percent” and insert “27.5 percent”.

On page 116, line 10, insert “and” after the semi-colon.

On page 116, line 12, strike “; and” and insert a period.

On page 116, strike lines 13 through 17.

On page 116, line 24, insert “and” after the semi-colon.

On page 117, line 2, strike “; and” and insert a period.

On page 117, strike lines 3 through 7.

On page 117, line 13, insert “and” after the semicolon.

On page 117, line 17, strike “; and” and insert a period.

On page 117, strike lines 18 through 23.

On page 118, line 6, insert “and” after the semicolon.

On page 118, in line 13, insert “or” after the semi-colon.

On page 118, line 14, strike “; or” and insert a period.

On page 118, strike line 15.

Beginning on page 118, strike line 16 and all that follows through page 119, line 9.

On page 119, line 10, strike “(F)” and insert “(E)”.

On page 119, line 15, strike “(G)” and insert “(F)”.

On page 119, line 19, strike “(C), (D), or (E)” and insert “(C), or (D)”.

On page 120, line 3, strike “(H)” and insert “(G)”.

On page 120, lines 5 and 6, strike “who is a dual eligible individual or an individual”.

Beginning on page 121, line 24, strike “dual eligible” and all that follows through “and” on page 122, line 1.

On page 146, line 6, insert before the period “and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c)”.

Beginning on page 146, strike line 23 and all that follows through page 149, line 21, and insert the following:

“(C) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALY ELIGIBLE BENEFICIARIES.—

“(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

“(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

“(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

“(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

“(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.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

“(i) 2006 is 95 percent;

“(ii) 2007 is 90 percent;

“(iii) 2008 is 85 percent;

“(iv) 2009 is 80 percent;

“(v) 2010 is 75 percent; or

“(vi) 2011, 2012 and 2013 is 70 percent.

“(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

Beginning on page 152, strike line 3 and all that follows through page 153, line 15, and insert the following:

“(f) DEFINITION.—For purposes of this section, the term ‘subsidy-eligible individual’ has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).”.

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(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) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

Beginning on page 157, strike line 21 and all that follows through page 158, line 4.

On page 173, beginning on line 15, strike “that is not” and all that follows through “includes” on line 18 on that page, and insert “that includes but is limited solely to”.

On page 190, in line 18, strike “and”.

On page 190, between lines 18 and 19, insert the following:

“(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and”.

On page 190, line 19, strike “(B)” and insert “(C)”.

SA 976. Mr. ROCKEFELLER (for himself, Mr. CARPER, Mr. GRAHAM of Florida, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DODD) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 51, strike lines 15 through 25 and insert the following:

“(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.

SA 977. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 134, strike line 9 and insert the following:

under paragraph (1).

“(d) IMPLEMENTATION OF PART D.—Notwithstanding section 1860D-1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2004. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall not implement sections 1807 and 1807A.

SA 978. Mr. JEFFORDS (for himself, Mr. KERRY, Mr. REID, Mr. DURBIN, and Mr. LAUTENBERG) submitted an amendment intended to be proposed by him to the bill S. 14, to enhance the energy security of the United States, and for other purposes; which was ordered to lie on the table; as follows:

On page 467, after line 16, add the following:

Subtitle I—Renewable Portfolio Standard
SEC. 192. RENEWABLE PORTFOLIO STANDARD.

Title VI of the Public Utility Regulatory Policies Act of 1978 (16 U.S.C. 2601 et seq.) is amended by adding at the end the following: “**SEC. 606. FEDERAL RENEWABLE PORTFOLIO STANDARD.**

“(a) RENEWABLE ENERGY REQUIREMENTS.—

“(1) IN GENERAL.—For each calendar year beginning in Calendar year 2006, each retail

electric supplier shall submit to the Secretary, not later than April 30 of each year, renewable energy credits in an amount equal to the required annual percentage of the retail electric supplier’s total amount of kilowatt-hours of non-hydropower (excluding incremental hydropower) electricity sold to retail consumers during the previous calendar year.

“(2) CARRYOVER.—A renewable energy credit for any year that is not used to satisfy the minimum requirement for that year may be carried over for use within the next two years.

“(b) REQUIRED ANNUAL PERCENTAGE.—Of the total amount of non-hydropower (excluding incremental hydropower) electricity sold by each retail electric supplier during a calendar year, the amount generated by renewable energy sources shall be not less than the percentage specified below:

	<i>Percentage of Renewable energy Calendar years: each year:</i>
2006–2009	5
2010–2014	10
2015–2019	15
2020 and subsequent years	20

“(c) SUBMISSION OF RENEWABLE ENERGY CREDITS.—

“(1) IN GENERAL.—To meet the requirements under subsection (a), a retail electric supplier shall submit to the Secretary either—

“(A) renewable energy credits issued to the retail electric supplier under subsection (e);

“(B) renewable energy credits obtained by purchase or exchange under subsection (f);

“(C) renewable energy credits purchased from the United States under subsection (g); or

“(D) any combination of credits under subsections (e), (f) or (g).

“(2) PROHIBITION ON DOUBLE COUNTING.—A credit may be counted toward compliance with subsection (a) only once.

“(d) RENEWABLE ENERGY CREDIT PROGRAM.—The Secretary shall establish, not later than 1 year after the date of enactment of this Act, a program to issue, monitor the sale or exchange of, and track, renewable energy credits.

“(e) ISSUANCE OF RENEWABLE ENERGY CREDITS.—

“(1) IN GENERAL.—Under the program established in subsection (d), an entity that generates electric energy through the use of a renewable energy resource may apply to the Secretary for the issuance of renewable energy credits.

“(2) APPLICATION.—An application for the issuance of renewable energy credits shall indicate—

“(A) the type of renewable energy resource used to produce the electric energy;

“(B) the State in which the electric energy was produced; and

“(C) any other information the Secretary determines appropriate.

“(3) CREDIT VALUE.—Except as provided in subparagraph (4), the Secretary shall issue to an entity applying under this subsection one renewable energy credit for each kilowatt-hour of renewable energy generated in any State from the date of enactment of this Act and in each subsequent calendar year.

“(4) CREDIT VALUE FOR DISTRIBUTED GENERATION.—The Secretary shall issue three renewable energy credits for each kilowatt-hour of distributed generation.

“(5) VESTING.—A renewable energy credit will vest with the owner of the system or facility that generates the renewable energy unless such owner explicitly transfers the credit.

“(6) CREDIT ELIGIBILITY.—To be eligible for a renewable energy credit, the unit of elec-

tricity generated through the use of a renewable energy resource shall be sold for retail consumption or used by the generator. If both a renewable energy resource and a non-renewable energy resource are used to generate the electric energy, the Secretary shall issue renewable energy credits based on the proportion of the renewable energy resource used.

“(7) IDENTIFYING CREDITS.—The Secretary shall identify renewable energy credits by the type and date of generation.

“(8) SALE UNDER PURPA CONTRACT.—When a generator sells electric energy generated through the use of a renewable energy resource to a retail electric supplier under a contract subject to section 210 of the Public Utilities Regulatory Policies Act of 1978 (16 U.S.C. 824a–3), the retail electric supplier is treated as the generator of the electric energy for the purposes of this Act for the duration of the contract.

“(f) SALE OR EXCHANGE OF RENEWABLE ENERGY CREDITS.—A renewable energy credit may be sold or exchanged by the entity issued the renewable energy credit or by any other entity that acquires the renewable energy credit. Credits may be sold or exchanged in any manner not in conflict with existing law, including on the spot market or by contractual arrangements of any duration.

“(g) PURCHASE FROM THE UNITED STATES.—The Secretary shall offer renewable energy credits for sale at the lesser of three cents per kilowatt-hour or 110 percent of the average market value of credits for the applicable compliance period. On January 1 of each year following calendar year 2006, the Secretary shall adjust for inflation the price charged per credit for such calendar year.

“(h) STATE PROGRAMS.—Nothing in this section shall preclude any State from requiring additional renewable energy generation in the State under any renewable energy program conducted by the State.

“(i) CONSUMER ALLOCATION.—The rates charged to classes of consumers by a retail electric supplier shall reflect a proportional percentage of the cost of generating or acquiring the required annual percentage of renewable energy under subsection (a). A retail electric supplier shall not represent to any customer or prospective customer that any product contains more than the percentage of eligible resources if the additional amount of eligible resources is being used to satisfy the renewable generation requirement under subsection (a).

“(j) ENFORCEMENT.—A retail electric supplier that does not submit renewable energy credits as required under subsection (a) shall be liable for the payment of a civil penalty. That penalty shall be calculated on the basis of the number of renewable energy credits not submitted, multiplied by the lesser of 4.5 cents or 300 percent of the average market value of credits for the compliance period.

“(k) INFORMATION COLLECTION.—The Secretary may collect the information necessary to verify and audit—

“(1) the annual electric energy generation and renewable energy generation of any entity applying for renewable energy credits under this section;

“(2) the validity of renewable energy credits submitted by a retail electric supplier to the Secretary; and

“(3) the quantity of electricity sales of all retail electric suppliers.

“(l) VOLUNTARY PARTICIPATION.—The Secretary may issue a renewable energy credit pursuant to subsection (e) to any entity not subject to the requirements of this Act only if the entity applying for such credit meets the terms and conditions of this Act to the same extent as entities subject to this Act.

“(m) STATE RENEWABLE ENERGY GRANT PROGRAM.

“(1) DISTRIBUTION TO STATES.—The Secretary shall distribute amounts received from sales under subsection (g) and from amounts received under subsection (j) to States to be used for the purposes of this section.

“(2) REGIONAL EQUITY PROGRAM.—

“(A) ESTABLISHMENT OF PROGRAM.—Within one year from the date of enactment of this Act, the Secretary shall establish a program to promote renewable energy production and use consistent with the purposes of this section.

“(B) ELIGIBILITY.—The Secretary shall make funds available under this section to State energy agencies for grant programs for—

“(i) renewable energy research and development;

“(ii) loan guarantees to encourage construction of renewable energy facilities;

“(iii) consumer rebate or other programs to offset costs of small residential or small commercial renewable energy systems including solar hot water; or

“(iv) promoting distributed generation.

“(3) ALLOCATION PREFERENCES.—In allocating funds under the program, the Secretary shall give preference to

“(A) States in regions which have a disproportionately small share of economically sustainable renewable energy generation capacity; and

“(B) State grant programs most likely to stimulate or enhance innovative renewable energy technologies.

“(n) DEFINITIONS.—In this section:

“(1) BIOMASS.—

“(A) IN GENERAL.—The term “biomass” means—

“(i) organic material from a plant that is planted for the purpose of being used to produce energy;

“(ii) nonhazardous, cellulosic or agricultural waste material that is segregated from other waste materials and is derived from—

“(I) a forest-related resource, including—

“(aa) mill and harvesting residue;

“(bb) precommercial thinnings;

“(cc) slash; and

“(dd) brush;

“(II) agricultural resources, including—

“(aa) orchard tree crops;

“(bb) vineyards;

“(cc) grains;

“(dd) legumes;

“(ee) sugar; and

“(ff) other crop by-products or residues; or

“(III) miscellaneous waste such as—

“(aa) waste pallet;

“(bb) crate; and

“(cc) landscape or right-of-way tree trimmings;

“(iii) animal waste that is converted to a fuel rather than directly combusted, the residue of which is converted to a biological fertilizer, oil, or activated carbon.

“(B) EXCLUSIONS.—The term ‘biomass’ shall not include—

“(i) municipal solid waste that is incinerated;

“(ii) recyclable post-consumer waste paper;

“(iii) painted, treated, or pressurized wood;

“(iv) wood contaminated with plastics or metals; or

“(v) tires.

“(2) DISTRIBUTED GENERATION.—The term ‘distributed generation’ means reduced electricity consumption from the electric grid due to use by a customer of renewable energy generated at a customer site.

“(3) INCREMENTAL HYDROPOWER.—The term ‘incremental hydropower’ means additional generation achieved from increased efficiency after January 1, 2003, at a hydroelectric dam that was placed in service before January 1, 2003.

“(4) LANDFILL GAS.—The term ‘landfill gas’ means gas generated from the decomposition

of household solid waste, commercial solid waste, and industrial solid waste disposed of in a municipal solid waste landfill unit (as those terms are defined in regulations promulgated under subtitle D of the Solid Waste Disposal Act (42 U.S.C. 6941 et seq.)).

“(5) RENEWABLE ENERGY.—The term ‘renewable energy’ means electricity generated from

“(A) a renewable energy source; or

“(B) hydrogen that is produced from a renewable energy source.

“(5) RENEWABLE ENERGY SOURCE.—The term ‘renewable energy source’ means—

“(A) wind;

“(B) ocean waves;

“(C) biomass;

“(D) solar;

“(E) landfill gas;

“(F) incremental hydropower; or

“(G) geothermal.

“(6) RETAIL ELECTRIC SUPPLIER.—The term ‘retail electric supplier’ means a person or entity that sells retail electricity to consumers, and which sold not less than 500,000 megawatt-hours of electric energy to consumers for purposes other than resale during the preceding calendar year.

“(7) SECRETARY.—The term ‘Secretary’ means the Secretary of Energy.

SA 979. Mr. AKAKA (for himself, Mr. SARBANES, and Ms. MIKULSKI) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. . NEGOTIATIONS BY THE OFFICE OF PERSONNEL MANAGEMENT.

The Office of Personnel Management may not negotiate a prescription drug benefit for any health benefits plan under chapter 89 of title 5, United States Code, that would provide a prescription drug benefit to a medicare eligible enrollee in that plan that is of lesser actuarial value, based on 2003 constant dollars, than the prescription drug benefit available to a medicare eligible enrollee of such plan on the date of enactment of this Act.

SA 980. Mr. AKAKA proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 636, line 16, insert “and citizens of the Freely Associated States, which include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, lawfully residing in the United States” after “Act”.

SA 981. Mr. PRYOR proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, add the following:

SEC. . EQUAL ACCESS TO COMPETITIVE GLOBAL PRESCRIPTION MEDICINE PRICES FOR AMERICAN PURCHASERS.

(a) DEFINITION OF COVERED PRODUCT.—In this section, the term “covered product” has

the meaning given the term in section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

(b) PROHIBITION.—It shall be unlawful for the manufacturer of a covered product or any other person that sells a covered product to refuse to sell to any wholesaler or retailer (or other purchaser representing a group of wholesalers or retailers) of covered products in the United States on terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other term that effectively reduces the cost to the manufacturer of supplying the drug) that are not substantially the same as the most favorable (to the purchaser) terms on which the person has sold or has agreed to sell the covered product to any purchaser in Canada.

(c) ENFORCEMENT.—The Secretary of Health and Human Services, or any wholesaler or retailer in the United States aggrieved by a violation of subsection (b), may bring a civil action in United States district court against a person that violates subsection (b) for an order—

(1) enjoining the violation; and

(2) awarding damages in the amount that is equal to 3 times the amount of the value of the difference between—

(A) the terms on which the person sold a covered product to the wholesaler or retailer; and

(B) the terms on which the person sold the covered product to a person in Canada.

(d) EFFECTIVENESS OF SECTION.—This section takes effect on the date that is 2 years after the date of enactment of this Act, except that this section shall not be in effect during any period after that date in which there is in effect a final regulation promulgated by the Secretary of Health and Human Services permitting the importation or reimportation of prescription drugs under section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

SA 982. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, insert the following:

SEC. . IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

SA 983. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 676, after line 22, insert the following:

SEC. . PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.

Section 1804(c) of the Social Security Act (42 U.S.C. 1395b-2(c)) is amended—

(1) by redesignating paragraphs (1) through (4) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking “The notice” and inserting “(1) The notice”; and

(3) by adding at the end the following:

“(2)(A) The Secretary shall annually provide each medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided to each such beneficiary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

“(B) In this section:

“(i) The term ‘advance directive’ has the meaning given such term in section 1866(f)(3).

“(ii) The term ‘medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, of this title.”.

SA 984. Mr. BINGAMAN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

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

SEC. ____ CARVING OUT DSH PAYMENTS FROM PAYMENTS TO MEDICARE+CHOICE AND MEDICAREADVANTAGE ORGANIZATIONS AND PAYING THE AMOUNTS DIRECTLY TO DSH HOSPITALS ENROLLING MEDICARE+CHOICE AND MEDICAREADVANTAGE ENROLLEES.

(a) REMOVAL OF DSH PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(1) UNDER MEDICARE+CHOICE.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3) and as amended by section 203) is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (E)”; and

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

“(E) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).”.

(2) UNDER MEDICAREADVANTAGE.—Section 1853(a)(5) (as amended by section 203) is amended by adding at the end the following new subparagraph:

“(C) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).”.

(3) EFFECTIVE DATES.—The amendments made—

(A) by paragraph (1) shall apply to plan years beginning on and after January 1, 2004

and shall continue to apply to plan years beginning on and after January 1, 2006; and

(B) by paragraph (2) shall apply to plan years beginning on and after January 1, 2006.

(b) ADDITIONAL DSH PAYMENTS FOR MANAGED CARE ENROLLEES.—Section 1886(d)(5)(F) ((42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking “clause (ix)” and inserting “clauses (ix) and (xvi)”; and

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

“(xvi)(I) For portions of cost reporting periods occurring on or after January 1, 2004, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that is a disproportionate share hospital (as described in clause (i)).

“(II) For purposes of this clause the term ‘applicable discharge’ means the discharge of any individual who is enrolled under a risk-sharing contract with a eligible organization under section 1876 and who is entitled to benefits under part A and any individual who is enrolled with a Medicare+Choice organization or a MedicareAdvantage organization under part C.

“(III) The amount of the payment under this clause with respect to any applicable discharge shall be equal to the estimated average per discharge amount that would otherwise have been paid under this subparagraph if the individuals had not been enrolled as described in subclause (II).

“(IV) The Secretary shall establish rules for paying an additional amount for any hospital reimbursed under a reimbursement system authorized under 1814(b)(3) if such hospital would qualify as a disproportionate share hospital under clause (i) were it not so reimbursed. Such payment shall be determined in the same manner as the amount of payment is determined under this clause for disproportionate share hospitals.”.

SA 985. Mr. BAUCUS (for Mr. EDWARDS (for himself and Mr. HARKIN)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end, add the following:

TITLE ____ DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ____ 01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following “(including whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)”; and

(2) in subsection (d)(5)—

(A) by inserting “(A)” after “will”; and

(B) by inserting after “thereof” the following: “or (B) offer a benefit with respect to safety, effectiveness, or cost (including effectiveness with respect to a sub population or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug”.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after “effectiveness” the following: “(includ-

ing effectiveness in comparison to other drugs for substantially the same condition or conditions)”.

(c) REGULATIONS.—

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

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

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

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

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

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

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

(ii) information relating to side effects and contraindications;

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

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

SEC. ____ 02. CIVIL PENALTY.

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

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

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

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

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

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

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

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

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

SEC. ____ 03. REPORTS.

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

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

(2) identifies, for each such advertisement—

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

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

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

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

SEC. 4. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

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

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

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

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

SA 986. Mr. BAUCUS (for Mr. LAUTENBERG (for himself, Mr. REED, Mrs. CLINTON, and Mr. CORZINE)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the end of title I, insert the following:
SEC. IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

SA 987. Mrs. HUTCHISON (for herself, Mr. KENNEDY, Mr. DURBIN, Mr. KERRY, Mr. TALENT, Mr. REED, Mrs. MURRAY, Mr. SPECTER, Mrs. FEINSTEIN, Mr. CORZINE, Mr. BIDEN, Mr. BOND, and Mr. SCHUMER) submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

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

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

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

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

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

“(VII) during fiscal year 2003, ‘c’ is equal to 1.35; and

“(VIII) on or after October 1, 2003, ‘c’ is equal to 1.6.”

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

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

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

SA 988. Mr. THOMAS (for himself and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

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

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

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

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

“(W) marriage and family therapist services (as defined in subsection (ww)(1)) and mental health counselor services (as defined in subsection (ww)(3));”

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

“Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

“(ww)(1) The term ‘marriage and family therapist services’ means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

“(2) The term ‘marriage and family therapist’ means an individual who—

“(A) possesses a master’s or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

“(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

“(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

“(3) The term ‘mental health counselor services’ means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

“(4) The term ‘mental health counselor’ means an individual who—

“(A) possesses a master’s or doctor’s degree in mental health counseling or a related field;

“(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

“(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.”

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

“(v) marriage and family therapist services and mental health counselor services;”

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking “and (U)” and inserting “(U);” and

(B) by inserting before the semicolon at the end the following: “, and (V) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(W), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L).”

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended in section 301(a), is amended by inserting “marriage and family therapist services (as defined in subsection (ww)(1)), mental health counselor services (as defined in section 1861(ww)(3)),” after “qualified psychologist services.”

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

“(vii) A marriage and family therapist (as defined in section 1861(ww)(2)).

“(viii) A mental health counselor (as defined in section 1861(ww)(4)).”

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or by a clinical social worker (as defined in subsection (hh)(1)),” and inserting “, by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (ww)(2)), or by a mental health counselor (as defined in subsection (ww)(4)).”

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or a marriage and family therapist (as defined in subsection (ww)(2))” after “social worker”.

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting “marriage and family therapist (as defined in subsection (ww)(2)),” after “social worker.”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2004.

SA 989. Ms. COLLINS submitted an amendment intended to be proposed by her to the bill S. 1, to amend title

XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in subtitle C of title IV, insert the following:

SEC. ____ INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended by adding at the end the following:

“(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

“(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2003 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

“(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).”

(b) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395fff(b)(5)) is amended by adding at the end the following: “Notwithstanding this paragraph, the total amount of the additional payments or payment adjustments made under this paragraph may not exceed, with respect to fiscal year 2004, 3 percent, and, with respect to fiscal years 2005 and 2006, 4 percent, of the total payments projected or estimated to be made based on the prospective payment system under this subsection in the year involved.”

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

SA 990. Mrs. MURRAY proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

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

SEC. ____ IMPROVEMENTS IN MEDICARE-ADVANTAGE BENCHMARK DETERMINATIONS.

(a) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w-23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting “who are enrolled in a Medicare Advantage plan” after “the average number of medicare beneficiaries”.

(b) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w-23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE ADVANTAGE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (E)”; and

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

“(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.”

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w-23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”; and

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

“(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

SA 991. Mr. HARKIN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

TITLE ____—MEDICAID DEMONSTRATION PROJECTS

SEC. ____01. SHORT TITLE.

This title may be cited as the “Money Follows the Person Act of 2003”.

SEC. ____02. FINDINGS.

Congress makes the following findings:

(1) In his budget for fiscal year 2004, President George W. Bush proposes a “Money Follows the Person” rebalancing initiative under the medicaid program to help States rebalance their long-term services support systems more evenly between institutional and community-based services.

(2) The President, by proposing this initiative, and Congress, recognize that States have not fully developed the systems needed to create a more equitable balance between institutional and community-based services spending under the medicaid program.

(3) While a few States have been successful at achieving this balance, nationally, approximately 70 percent of the medicaid funding spent for long-term services is devoted to nursing facilities and intermediate care facilities for the mentally retarded. Only 30 percent of such funding is spent for community-based services.

(4) As a result, there are often long waiting lists for community-based services and supports.

(5) In the Americans with Disabilities Act of 1990, Congress found that individuals with disabilities continue to encounter various forms of discrimination, including segregation, and that discrimination persists in such critical areas as institutionalization.

(6) In 1999, the Supreme Court held in *Olmstead v. LC* (527 U.S. 581 (1999)) that needless institutionalization is discrimination under the Americans with Disabilities Act of 1990, noting that institutional placement of people who can be served in the community “perpetuates unwarranted assumptions that persons so isolated are unworthy of participating in community life.” (Id. at 600). The Court further found that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” (Id. at 601).

(7) Additional resources would be helpful for assisting States in rebalancing their long-term services support system and complying with the *Olmstead* decision.

SEC. ____03. AUTHORITY TO CONDUCT MEDICAID DEMONSTRATION PROJECTS.

(a) DEFINITIONS.—In this section:

(1) COMMUNITY-BASED SERVICES AND SUPPORTS.—The term “community-based services and supports” means, with respect to a State, any items or services that are an allowable expenditure for medical assistance under the State medicaid program, or under a waiver of such program and that the State determines would allow an individual to live in the community.

(2) INDIVIDUAL’S REPRESENTATIVE; REPRESENTATIVE.—The terms “individual’s representative” and “representative” mean a parent, family member, guardian, advocate, or authorized representative of an individual.

(3) MEDICAID LONG-TERM CARE FACILITY.—The term “medicaid long-term care facility” means a hospital, nursing facility, or intermediate care facility for the mentally retarded, as such terms are defined for purposes of the medicaid program.

(4) MEDICAID PROGRAM.—The term “medicaid program” means the State medical assistance program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

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

(6) STATE.—The term “State” has the meaning given such term for purposes of the medicaid program.

(b) STATE APPLICATION.—A State may apply to the Secretary for approval to conduct a demonstration project under which the State shall provide community-based services and supports to individuals—

(1) who are eligible for medical assistance under the medicaid program;

(2) who are residing in a medicaid long-term care facility and who have resided in such facility for at least 90 days; and

(3) with respect to whom there has been a determination that but for the provision of community-based services and supports, the individuals would continue to require the level of care provided in a medicaid long-term care facility.

(c) REQUIREMENTS.—A State is not eligible to conduct a demonstration project under this section unless the State certifies the following:

(1) With respect to any individual provided community-based services and supports under the demonstration project, the State shall continue to provide community-based services and supports to the individual under the medicaid program (and at the State’s Federal medical assistance percentage (as

defined in section 1905(b) of the Social Security Act) reimbursement rate), for as long as the individual remains eligible for medical assistance under the State medicaid program and continues to require such services and supports, beginning with the month that begins after the 12-month period in which the individual is provided such services and supports under the demonstration project.

(2) The State shall allow an individual participating in the demonstration project (or, as appropriate, the individual's representative) to choose the setting in which the individual desires to receive the community-based services and supports provided under the project.

(3) The State shall identify and educate individuals residing in a medicaid long-term care facility who are eligible to participate in the demonstration project (and, as appropriate the individual's representative) about the opportunity for the individual to receive community-based services and supports under the demonstration project.

(4) The State shall ensure that each individual identified in accordance with paragraph (3) (and, as appropriate, the individual's representative), has the opportunity, information, and tools to make an informed choice regarding whether to transition to the community through participation in the demonstration project or to remain in the medicaid long-term care facility.

(5) The State shall maintain an adequate quality improvement system so that individuals participating in the demonstration project receive adequate services and supports.

(6) The State shall conduct a process for public participation in the design and development of the demonstration project and such process shall include the participation of individuals with disabilities, elderly individuals, or individuals with chronic conditions who are part of the target populations to be served by the demonstration project, and the representatives of such individuals.

(7) The Federal funds paid to a State pursuant to this section shall only supplement, and shall not supplant, the level of State funds expended for providing community-based services and supports for individuals under the State medicaid program as of the date the State application to conduct a demonstration project under this section is approved.

(d) APPROVAL OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall conduct a competitive application process with respect to applications submitted under subsection (b) (taking into consideration the preferences provided under paragraph (2)) that meet the requirements of subsection (c). In determining whether to approve such an application, the Secretary may waive the requirement of—

(A) section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) to allow for sub-State demonstrations;

(B) section 1902(a)(10)(B) of such Act (42 U.S.C. 1396a(a)(10)(B)) with respect to comparability; and

(C) section 1902(a)(10)(C)(i)(III) of such Act (42 U.S.C. 1396a(a)(10)(C)(i)(III)) with respect to income and resource limitations.

(2) PREFERENCE FOR CERTAIN APPLICATIONS.—In approving applications to conduct demonstration projects under this section, the Secretary shall give preference to approving applications that indicate that the State shall do the following:

(A) Design and implement enduring improvements in community-based long-term services support systems within the State to enable individuals with disabilities to live and participate in community life, particularly with respect to those practices that

will ensure the successful transition of such individuals from medicaid long-term care facilities into the community.

(B) Design and implement a long-term services support system in the State that prevents individuals from entering medicaid long-term care facilities in order to gain access to community-based services and supports.

(C) Engage in systemic reform activities within the State to rebalance expenditures for long-term services under the State medicaid program through administrative actions that reduce reliance on institutional forms of service and build up more community capacity.

(D) Address the needs of populations that have been underserved with respect to the availability of community services or involve individuals or entities that have not previously participated in the efforts of the State to increase access to community-based services.

(E) Actively engage in collaboration between public housing agencies, the State medicaid agency, independent living centers, and other agencies and entities in order to coordinate strategies for obtaining community integrated housing and supportive services for an individual who participates in the demonstration project, both with respect to the period during which such individual participates in the project and after the individual's participation in the project concludes, in order to enable the individual to continue to reside in the community.

(F) Develop and implement policies and procedures that allow the State medicaid agency to administratively transfer or integrate funds from the State budget accounts that are obligated for expenditures for medicaid long-term care facilities to other accounts for obligation for the provision of community-based services and supports (including accounts related to the provision of such services under a waiver approved under section 1915 of the Social Security Act (42 U.S.C. 1396n)) when an individual transitions from residing in such a facility to residing in the community.

(e) PAYMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall pay to each State with a demonstration project approved under this section an amount for each quarter occurring during the period described in paragraph (2) equal to 100 percent of the State's expenditures in the quarter for providing community-based services and supports to individuals participating in the demonstration project.

(2) PERIOD DESCRIBED.—The period described in this paragraph is the 12-month period that begins on the date on which an individual first receives community-based services and supports under the demonstration project in a setting that is not a medicaid long-term care facility and is selected by the individual.

(f) REPORTS.—

(1) IN GENERAL.—Each State conducting a demonstration project under this section shall submit a report to the Secretary that, in addition to such other requirements as the Secretary may require, includes information regarding—

(A) the types of community-based services and supports provided under the demonstration project;

(B) the number of individuals served under the project;

(C) the expenditures for, and savings resulting from, conducting the project; and

(D) to the extent applicable, the changes in State's long-term services system developed in accordance with the provisions of subsection (d)(2).

(2) UNIFORM DATA FORMAT.—In requiring information under this subsection, the Sec-

retary shall develop a uniform data format to be used by States in the collection and submission of data in the State report required under paragraph (1).

(g) EVALUATIONS.—The Secretary shall use an amount, not to exceed one-half of 1 percent of the amount appropriated under subsection (h) for each fiscal year, to provide, directly or through contract—

(1) for the evaluation of the demonstration projects conducted under this section;

(2) technical assistance to States concerning the development or implementation of such projects; and

(3) for the collection of the data described in subsection (f)(1).

(h) FUNDING.—There is appropriated to carry out this section, \$350,000,000 for each of fiscal years 2004 through 2008. Funds appropriated under the preceding sentence for a fiscal year shall remain available until expended, but not later than September 30, 2008.

SEC. 404. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

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

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

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

(B) in subparagraph (B)—

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

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

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

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

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

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

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

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

claim against the primary plan or the primary plan's insured, or by other means."; and

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

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

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

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

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

SA 992. Mr. BAUCUS (for Ms. STABENOW (for herself and Ms. SNOWE)) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

On page 158, between lines 4 and 5, insert the following:

(f) CLARIFICATION OF STATE AUTHORITY RELATING TO MEDICAID DRUG REBATE AGREEMENTS.—Section 1927 (42 U.S.C. 1396r-8) is amended by adding at the end the following:

"(1) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State from—

"(1) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection) that are similar to a rebate agreement described in subsection (b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by residents of a State who are not otherwise eligible for medical assistance under this title; or

"(2) making prior authorization (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement."

SA 993. Mr. BAUCUS (for Mr. DORGAN) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

At the appropriate place in title IV, insert the following:

SEC. —. COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

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

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

"(W) cardiovascular screening tests (as defined in subsection (ww)(1));"

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

"Cardiovascular Screening Tests

"(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

"(A) Tests for the determination of cholesterol levels.

"(B) Tests for the determination of lipid levels of the blood.

"(C) Such other tests for cardiovascular disease as the Secretary may approve.

"(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

"(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years."

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking "and" at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

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

"(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2)."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SA 994. Mr. DURBIN (for himself, Mr. CORZINE, Mr. HARKIN, Mrs. BOXER, Ms. STABENOW, Mr. DAYTON, and Mr. BYRD) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; as follows:

Beginning on page 48, strike line 13 through page 50, line 2 and insert the following:

"(1) NO DEDUCTIBLE.—

"(A) IN GENERAL.—The coverage provides for benefits without the application of a deductible.

"(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply section 1860D-19(a)(3)(A)(ii).

"(2) LIMITS ON COST-SHARING.—

"(A) IN GENERAL.—The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under paragraph (4)) that is equal to 30 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 30 percent of such costs.

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

On page 50, line 15, strike "\$3,700" and insert "\$1,500".

On page 51, strike lines 15 through 25 and insert the following:

"(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.

Beginning on page 77, strike line 10 and all that follows through page 84, line 7, and insert the following:

"(e) MEDICARE OPERATED PLAN OPTION.—

"(1) ACCESS.—The Administrator shall establish and operate a national plan to provide any eligible beneficiary enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a Medicare Advantage plan) electing such plan with standard prescription drug coverage. Under such plan, the Administrator shall negotiate with pharmaceutical manufacturers with respect to the purchase price of covered drugs and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Administrator shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, to reduce the purchase cost of covered drugs. Eligible beneficiaries enrolled under this part shall have the option of enrolling in such plan or in a Medicare Prescription Drug plan or a Medicare Advantage plan available in the area in which the beneficiary resides.

"(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

"(A) IN GENERAL.—In the case of an eligible beneficiary enrolled in the plan operated by the Administrator under paragraph (1), the monthly beneficiary obligation of such beneficiary for such enrollment shall be—

"(i) for months in the first year of implementation, \$35; and

"(ii) for months in a subsequent year, the lesser of—

"(I) the amount determined under this paragraph for months in the previous year, increased by the annual percentage increase described in section 1860D-6(c)(5) for the year involved; or

"(II) in the case of months in years prior to 2014, the specified amount.

"(B) SPECIFIED AMOUNT.—For purposes of this paragraph, the term 'specified amount' means—

"(i) for months in the second year of implementation, \$37;

"(ii) for months in the third year of implementation, \$40;

"(iii) for months in the fourth year of implementation, \$43;

"(iv) for months in the fifth year of implementation, \$46;

"(v) for months in the sixth year of implementation, \$51;

"(vi) for months in the seventh year of implementation, \$54; and

"(vii) for months in the eighth year of implementation, \$59.

"(3) NO AFFECT ON ACCESS REQUIREMENTS.—The plan operated by the Administrator under paragraph (1) shall be in addition to the plans required under subsection (d)(1).

"(4) REQUIREMENT TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to

eligible beneficiaries enrolled in the plan operated by the Administrator under paragraph (1) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a Medicare Advantage plan (with respect to qualified prescription drug coverage), the Administrator shall adjust the requirements or payments under such a contract to eliminate such excess.

“(f) TWO-YEAR CONTRACTS.—A contract approved under this section for a Medicare Prescription Drug plan shall be for a 2-year period.

“(g) IMPLEMENTATION OF PART D.—Notwithstanding any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part as soon as practicable after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, but in no case later than January 1, 2006. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part.

On page 134, strike line 9 and insert the following:

“(d) SPECIAL RULES FOR STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

“(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of the sponsor of a State pharmaceutical assistance program that seeks to offer a Medicare Prescription Drug plan under this part, the following special rules apply:

“(A) WAIVER OF LICENSURE.—Section 1860D-7(a)(1) shall not apply.

“(B) PERMITTING LIMITATION ON ENROLLMENT.—The sponsor may restrict eligibility to enroll in the plan to those low-income individuals who qualify (or meet the standards for qualification) for the State pharmaceutical assistance program.

“(C) OTHER REQUIREMENTS.—The Administrator may waive such other requirements of this part as the Administrator finds appropriate to promote the role of State pharmaceutical assistance programs under this part.

“(2) DEFINITION.—For purposes of this part, the term ‘State pharmaceutical assistance program’ means a program, in operation as of the date of enactment of this title, that is sponsored or underwritten by a State, that was established pursuant to a waiver under section 1115 or otherwise, and that provides financial assistance with out-of-pocket expenses with respect to covered outpatient drugs for individuals in the State who meet income-related qualifications specified under such program.

“(3) CONSTRUCTION.—Nothing in this subsection shall affect the provisions of subsection (b).”

At the end of title VI, add the following:

SEC. . NEED FOR RENEWAL.

(a) IN GENERAL.—Notwithstanding any other provision of law, the provisions of, and amendments made by, this Act shall remain in effect but shall be superseded by the Director of the Office of Management and Budget on the date that the total of the increased Federal expenditures by reason of such amendments and provisions has reached \$400,000,000.

(b) APPLICATION.—Any provision of law amended or effected by this Act shall be applied and administered after the date described in subsection (a) as if the provisions of, and amendments made by, this Act had never been enacted.

(c) NOTIFICATION.—The Director of the Office of Management and Budget shall notify Congress 6 months prior to the date that the provisions of, and amendments made by, this Act will be superseded pursuant to subsection (a).

SA 995. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. . ELIMINATION OF LIMITATION ON WORK GEOGRAPHIC ADJUSTMENT UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848(e)(1)(A)(iii) (42 U.S.C. 1395w-4(e)(1)(A)(iii)) is amended by inserting “(or, for purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, 100 percent)” after “¼”.

SA 996. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

In section 445(a) of the bill, strike paragraph (6) and insert the following:

“(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent;

“(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(iii)) to reflect ¼ of the area cost difference in physician work;

“(8) an evaluation of the effect of the adjustment described in paragraph (7) on physician location and retention in higher than average cost-of-living areas, taking into account difference in recruitment costs and retention rates for physicians, including specialists; and

“(9) an evaluation of the appropriateness of the ¼ adjustment for the work geographic practice cost index.”

SA 997. Mr. REED submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 401, between lines 4 and 5, insert the following:

“(C) EDUCATION AND OUTREACH CAMPAIGN.—

“(i) PROGRAM REQUIREMENTS.—

“(I) IN GENERAL.—The Office of Beneficiary Assistance, in collaboration with the Administrator of the Center for Medicare & Medicaid Services, shall conduct education and outreach programs that are designed to inform hard to reach populations, minority populations, and rural and frontier populations, about the medicare program, and particularly about the medicare fee-for-service program under parts A and B, and the prescription drug benefit established under part D and the plan options under that part, including the low-income subsidies provided under section 1860D-19.

“(II) DISSEMINATION.—Programs conducted under clause (i) shall produce and disseminate information in major languages, and shall conduct other outreach activities, including mailings and low-income subsidy en-

rollment assistance, in coordination with other appropriate Federal and State agencies.

“(III) SITES.—Outreach and enrollment assistance activities shall be conducted under such programs at sites that provide, determine eligibility for, or enroll, low-income individuals under other Federal, State, or local assistance programs, including such sites operated under Federal, State, or local low-income housing, energy, nutrition, health, and social services programs.

“(IV) COSTS.—The Administrator of the Center for Medicare Choices shall reimburse other Federal, State, and local agencies for the expenses such agencies incur that are attributable to providing coordination with the education and outreach programs conducted under this subparagraph. The Secretary shall determine the appropriate administrative expenses that are to be allocated between the Center for Medicare Choices and the Centers for Medicare & Medicaid Services as a result of the collaboration required under this clause.

“(ii) MODEL FORM.—

“(I) IN GENERAL.—The Office of Beneficiary Assistance, in coordination and cooperation with the Administrator of the Center for Medicare & Medicaid Services, shall devise a model application form for the premium and cost-sharing subsidies established under section 1860D-19 and shall make such form available for use by the States.

“(II) REQUIREMENTS.—The model form devised under subclause (I) shall be as simple as possible, shall be designed so that the form is capable of being completed without a face-to-face interview and of being filed electronically, and shall apply for multiyear periods, with beneficiaries required to report any disqualifying increases in income or assets to the Administrator of the Center for Medicare Choices.

SA 998. Mr. DODD submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 129, strike lines 3 through 20, and insert the following:

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

SA 999. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 389, between lines 6 and 7, insert the following:

SEC. . PRIORITY AREA QUALITY INDICATORS.

(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Quality Interagency Coordination Task Force, the Institute of Medicine, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the American Health Quality Association, the

National Quality Forum, and other individuals and organizations determined appropriate by the Secretary of Health and Human Services, shall assemble, evaluate, and, where necessary, develop or update quality indicators for each of the 20 priority areas for improvement in health care quality as identified by the Institute of Medicine in their report entitled "Priority Areas for National Action" in 2003, in order to assist medicare beneficiaries in making informed choices about health plans. The selection of appropriate quality indicators under this subsection shall include the evaluation criteria formulated by clinical professionals, consumers, data collection experts.

(b) RISK ADJUSTMENT.—In developing the quality indicators under subsection (a), the Director of the Agency for Healthcare Research and Quality shall ensure that adequate risk adjustment is provided for.

(c) BEST PRACTICES.—In carrying out this section, the Director of the Agency for Healthcare Research and Quality shall—

(1) assess data concerning appropriate clinical treatments based on the best scientific evidence available;

(2) determine areas in which there is insufficient evidence to determine best practices; and

(3) compare existing quality indicators to best clinical practices, validate appropriate indicators, and report on areas where additional research is needed before indicators can be developed.

(d) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Director of the National Institutes of Health a report concerning areas of clinical care requiring farther research necessary to establish effective clinical treatments that will serve as a basis for quality indicators; and

(2) submit to Congress a report on the state of quality measurement for priority areas that links data to the report submitted under paragraph (1) for the year involved.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$12,000,000 for fiscal year 2004, and \$8,000,000 for each of fiscal years 2005 through 2009.

SEC. ____ . STANDARDIZED QUALITY INDICATORS FOR FEDERAL AGENCIES.

(a) IN GENERAL.—In addition to other activities to be carried out by the Quality Interagency Coordination Taskforce (as established by executive order on March 13, 1998), such Taskforce shall standardize indicators of health care quality that are used in all Federal agencies, as appropriate.

(b) CONSULTATION.—In carrying out subsection (a), the Quality Interagency Coordination Taskforce shall consult with a public-private consensus organization (such as the National Quality Forum) to enhance the likelihood of the simultaneous application of the standardized indicators under subsection (a) in the private sector.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the progress made by the Quality Interagency Coordination Taskforce to standardizing quality indicators throughout the Federal Government.

SEC. ____ . DEMONSTRATION PROGRAM FOR COMMUNITY HEALTH CARE QUALITY DATA REPORTING.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality, shall award not to exceed 20 grants to eligible

communities for the establishment of demonstration programs for the reporting of health care quality information at the community level.

(b) QUALITY INDICATORS.—

(1) IN GENERAL.—For purposes of reporting information under the demonstration programs under this section, indicators of health care quality may include the indicators developed for the 20 priority areas as identified by the Institute of Medicine in the report entitled "Priority Areas for National Action", 2003, or other indicators determined appropriate by the Secretary of Health and Human Services.

(2) TYPE OF DATA.—All quality indicators with respect to which reporting will be carried out under the demonstration program shall be reported by race, ethnicity, gender, and age.

(c) ELIGIBILITY.—The Secretary of Health and Human Services shall award grants to communities under this section based on competitive proposals and criteria to be determined jointly by the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality. Such criteria may include a demonstrated ability of the community to collect data on quality indicators and a demonstrated ability to effectively transmit community-level health status results to relevant stakeholders.

(d) TECHNICAL ADVISORY COMMITTEE.—The Secretary of Health and Human Services shall establish a technical advisory committee to assist grantees in data collection, data analysis, and report dissemination.

(e) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Congress a report on the results of the demonstration programs under this section; and

(2) make such reports publicly available, including by posting the reports on the Internet.

(f) EVALUATION.—The Secretary of Health and Human Services shall, upon awarding grants under subsection (a), enter into a contract for the evaluation of demonstration programs under this section. Such evaluation shall compare the effectiveness of such demonstration programs in collecting and reporting required data, and on the effectiveness of distributing information to key stakeholders in a timely fashion. Such evaluations shall provide for a report on best practices.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$25,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

SA 1000. Mrs. CLINTON submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. ____ . STUDY ON EFFECTIVENESS OF CERTAIN PRESCRIPTION DRUGS.

(a) IN GENERAL.—

(1) RESEARCH BY NIH.—The Director of the National Institutes of Health, in coordination with the Director of the Agency for Healthcare Research and Quality and the Commissioner of Food and Drugs, shall con-

duct research, which may include clinical research, to develop valid scientific evidence regarding the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(2) ANALYSIS BY AHRQ.—

(A) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, taking into consideration the research and data from the National Institutes of Health and the Food and Drug Administration, shall use evidence-based practice centers to synthesize available data or conduct other analyses of the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(B) SAFETY.—In any analysis of comparative effectiveness under this subparagraph, the Director of the Agency for Healthcare Research and Quality shall include a discussion of available information on relative safety.

(3) STANDARDS.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Commissioner of Food and Drugs, the Director of the National Institutes of Health, and with input from stakeholders, shall develop standards for the design and conduct of studies under this subsection.

(b) COVERED PRESCRIPTION DRUGS.—For purposes of this section, the term "covered prescription drugs" means prescription drugs that, as determined by the Director of the Agency for Healthcare Research and Quality in consultation with the Administrator of the Centers for Medicare & Medicaid Services, account for high levels of expenditures, high levels of use, or high levels of risk to individuals in federally funded health programs, including Medicare and Medicaid.

(c) DISSEMINATION.—

(1) ANNUAL REPORT.—Each year the Secretary shall prepare a report on the results of the research, studies, and analyses conducted by the National Institutes of Health and the Agency for Healthcare Research and Quality, and the Food and Drug Administration under this section and submit the report to the following:

(A) Congress.

(B) The Secretary of Defense.

(C) The Secretary of Veterans Affairs.

(D) The Administrator of the Centers for Medicare & Medicaid Services.

(E) The Director of the Indian Health Service.

(F) The Director of the National Institutes of Health.

(G) The Director of the Office of Personnel Management.

(H) The Commissioner of Food and Drugs.

(2) REPORTS FOR PRACTITIONERS.—As soon as possible, but not later than a year after the completion of any study pursuant to subsection (a)(2), the Director of the Agency for Healthcare Research and Quality shall—

(A) prepare a report on the results of such study for the purpose of informing health care practitioners; and

(B) transmit the report to the Director of the National Institutes of Health.

(3) FDA DRUG INFORMATION.—The Commissioner of Food and Drugs shall—

(A) review all data and information from studies and analyses conducted or prepared under this section; and

(B) develop appropriate summaries of such information for inclusion in adequate directions for use under section 502(f)(1) of the Federal Food, Drug, and Cosmetic Act and in summaries relating to side effects, contraindications, and effectiveness under section 502(n) of that Act.

(4) NIH INTERNET SITE.—The Director of the National Institutes of Health shall publish on the Institutes' Internet site and through other means that will facilitate access by practitioners, each report prepared under this subsection by the Director of the Agency for Healthcare Research and Quality.

(d) EVIDENCE.—In carrying out this section, the Director of the National Institutes of Health and the Agency for Healthcare Research and Quality shall consider only methodologically sound studies, giving preference to studies for which the Directors have access to sufficient underlying data and analysis to address any significant concerns about methodology or the reliability of data.

(e) AUTHORIZATIONS OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$75,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today's Executive Calendar: Calendar Nos. 160, 204, 205, 241, 243, 244, and 245. I further ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

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

The nominations considered and confirmed are as follows:

AIR FORCE

The following Air National Guard of the United States officers for appointment in the Reserve of the Air Force to the grades indicated under title 10, U.S.C., section 12203:

To be major general

- BRIGADIER GENERAL JOHN B. HANDY, 0000
- BRIGADIER GENERAL MARVIN S. MAYES, 0000
- BRIGADIER GENERAL DOUGLAS R. MOORE, 0000
- BRIGADIER GENERAL RICHARD L. TESTA, 0000

To be brigadier general

- COLONEL JOSEPH G. BALSUKUS, 0000
- COLONEL BOBBY L. BRITTAN, 0000
- COLONEL THOMAS J. DEARDORFF, 0000
- COLONEL MICHAEL P. HICKEY, 0000
- COLONEL CHARLES V. ICKES, II, 0000
- COLONEL WILLIAM B. JERNIGAN, 0000
- COLONEL HENRY C. MORROW, 0000
- COLONEL DONALD J. QUENNEVILLE, 0000
- COLONEL DANIEL R. SCACE, 0000
- COLONEL TIMOTHY W. SCOTT, 0000
- COLONEL EUGENE A. SEVI, 0000
- COLONEL DARRYLL D.M. WONG, 0000

AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

- MAJ. GEN. JOHN W. ROSA, JR., 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 8069:

To be major general

- BRIG. GEN. BARBARA C. BRANNON, 0000

DEPARTMENT OF HOMELAND SECURITY

FRANK LIBUTTI, OF NEW YORK, TO BE UNDER SECRETARY FOR INFORMATION ANALYSIS AND INFRASTRUCTURE PROTECTION, DEPARTMENT OF HOMELAND SECURITY.

COAST GUARD

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES COAST GUARD RESERVE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be rear admiral

- REAR ADM. (LH) DUNCAN C. SMITH, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER TITLE 14, U.S.C., SECTION 271:

To be rear admiral

- REAR ADM. (LH) SALLY BRICE-O'HARA, 0000
- REAR ADM. (LH) HARVEY E. JOHNSON, 0000
- REAR ADM. (LH) DAVID W. KUNKEL, 0000
- REAR ADM. (LH) DAVID B. PETERMAN, 0000

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT AS PERMANENT COMMISSIONED REGULAR OFFICER IN THE UNITED STATES COAST GUARD IN THE GRADE INDICATED UNDER TITLE 14, U.S.C., SECTION 211:

To be lieutenant

- MARY ANN C. GOSLING, 0000

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2003

Mr. GRASSLEY. I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 123, S. 239.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 239) to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. GRASSLEY. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

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

The bill (S. 239) was read the third time and passed, as follows:

S. 239

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Trauma Care Systems Planning and Development Act of 2003".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The Federal Government and State governments have established a history of cooperation in the development, implementation, and monitoring of integrated, comprehensive systems for the provision of emergency medical services.

(2) Trauma is the leading cause of death of Americans between the ages of 1 and 44 years and is the third leading cause of death in the general population of the United States.

(3) In 1995, the total direct and indirect cost of traumatic injury in the United States was estimated at \$260,000,000,000.

(4) There are 40,000 fatalities and 5,000,000 nonfatal injuries each year from motor vehicle-related trauma, resulting in an aggregate annual cost of \$230,000,000,000 in medical expenses, insurance, lost wages, and property damage.

(5) Barriers to the receipt of prompt and appropriate emergency medical services exist in many areas of the United States.

(6) The number of deaths from trauma can be reduced by improving the systems for the

provision of emergency medical services in the United States.

(7) Trauma care systems are an important part of the emergency preparedness system needed for homeland defense.

SEC. 3. AMENDMENTS.

(a) ESTABLISHMENT.—Section 1201 of the Public Health Service Act (42 U.S.C. 300d) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by inserting " , acting through the Administrator of the Health Resources and Services Administration," after "Secretary";

(B) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively;

(C) by inserting after paragraph (2) the following:

"(3) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas;"

(D) in paragraph (4), as redesignated by subparagraph (B)—

(i) by inserting "to enhance each State's capability to develop, implement, and sustain the trauma care component of each State's plan for the provision of emergency medical services" after "assistance"; and

(ii) by striking "and" after the semicolon;

(E) in paragraph (5), as redesignated by subparagraph (B), by striking the period at the end and inserting " , and"; and

(F) by adding at the end the following:

"(6) promote the collection and categorization of trauma data in a consistent and standardized manner;"

(2) in subsection (b), by inserting " , acting through the Administrator of the Health Resources and Services Administration," after "Secretary"; and

(3) by striking subsection (c).

(b) CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended—

(1) by striking section 1202; and

(2) by redesignating section 1203 as section 1202.

(c) ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.—Section 1202(a) of the Public Health Service Act, as such section was redesignated by subsection (b), is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting " , such as advanced trauma life support," after "model curricula";

(2) in paragraph (4), by striking "and" after the semicolon;

(3) in paragraph (5), by striking the period and inserting " , and"; and

(4) by adding at the end the following:

"(6) by increasing communication and coordination with State trauma systems."

(d) REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.—Section 1212 of the Public Health Service Act (42 U.S.C. 300d-12) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking "and" after the semicolon; and

(B) by striking subparagraph (B) and inserting the following:

"(B) for the third fiscal year of such payments to the State, not less than \$1 for each \$1 of Federal funds provided in such payments for such fiscal year;

"(C) for the fourth fiscal year of such payments to the State, not less than \$2 for each \$1 of Federal funds provided in such payments for such fiscal year; and

"(D) for the fifth fiscal year of such payments to the State, not less than \$2 for each