HR 1

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

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Sponsor

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Party: Republican • **State:** IL • **Chamber:** House

Cosponsors (20 total)

Cosponsor	Party / State	Role	Date Joined
Rep. Bilirakis, Michael [R-FL-9]	R · FL		Jun 25, 2003
Rep. Blunt, Roy [R-MO-7]	R · MO		Jun 25, 2003
Rep. Bradley, Jeb [R-NH-1]	R · NH		Jun 25, 2003
Rep. Brown-Waite, Ginny [R-FL-5]	R · FL		Jun 25, 2003
Rep. Burns, Max [R-GA-12]	R · GA		Jun 25, 2003
Rep. Capito, Shelley Moore [R-WV-2]	R · WV		Jun 25, 2003
Rep. DeLay, Tom [R-TX-22]	R · TX		Jun 25, 2003
Rep. Dunn, Jennifer [R-WA-8]	R · WA		Jun 25, 2003
Rep. Fletcher, Ernie [R-KY-6]	R · KY		Jun 25, 2003
Rep. Goss, Porter J. [R-FL-14]	R · FL		Jun 25, 2003
Rep. Graves, Sam [R-MO-6]	R · MO		Jun 25, 2003
Rep. Johnson, Nancy L. [R-CT-5]	R · CT		Jun 25, 2003
Rep. McCrery, Jim [R-LA-4]	R · LA		Jun 25, 2003
Rep. Nunes, Devin [R-CA-21]	R · CA		Jun 25, 2003
Rep. Peterson, Collin C. [D-MN-7]	D · MN		Jun 25, 2003
Rep. Pryce, Deborah [R-OH-15]	R · OH		Jun 25, 2003
Rep. Simmons, Rob [R-CT-2]	R · CT		Jun 25, 2003
Rep. Sullivan, John [R-OK-1]	R · OK		Jun 25, 2003
Rep. Tauzin, W. J. (Billy) [R-LA-3]	R · LA		Jun 25, 2003
Rep. Thomas, William M. [R-CA-22]	R · CA		Jun 25, 2003

Committee Activity

Committee	Chamber	Activity	Date
Energy and Commerce Committee	House	Referred to	Jun 25, 2003
Ways and Means Committee	House	Referred To	Jun 26, 2003

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
108 HRES 463	Procedurally related	**Nov 21, 2003:** Motion to reconsider laid on the table Agreed to without objection.
108 HR 2473	Related bill	**Jul 15, 2003:** Placed on the Union Calendar, Calendar No. 115.
108 S 1	Related document	**Jul 7, 2003:** See also H.R.1.
108 HR 2596	Related bill	**Jun 27, 2003:** Pursuant to the provisions of H. Res. 299, H.R. 2596 is laid on the table.
108 HRES 299	Related bill	**Jun 26, 2003:** Motion to reconsider laid on the table Agreed to without objection.
108 HR 2409	Related bill	**Jun 24, 2003:** Referred to the Subcommittee on Health.
108 S 1195	Related bill	**Jun 5, 2003:** Read twice and referred to the Committee on Finance.
108 HR 1382	Related bill	**Apr 10, 2003:** Referred to the Subcommittee on Health.

Summary (as of Dec 8, 2003)

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 - **Title I: Medicare Prescription Drug Benefit** (Sec. 101) Amends title XVIII (Medicare) of the Social Security Act (SSA) to add a new part D (Voluntary Prescription Drug Benefit Program). Establishes a new optional Medicare prescription drug benefit program augmenting with a comprehensive, flexible, and permanent voluntary prescription drug benefit program the limited coverage of certain outpatient prescription drugs, biologicals, and vaccines currently covered under the Medicare program under its original fee-for-service component under both Medicare parts A (Hospital Insurance) and B (Supplementary Medical Insurance) and under its managed care, medical savings account (MSA), and private fee-for-service component under Medicare part C (Medicare+Choice).

Provides under this new prescription drug benefit program for offering eligible Medicare beneficiaries, regardless of income or health status, access to more coverage options, options which provide enhanced benefits, with cost-sharing, and additional beneficiary protections and assistance, such as access to negotiated prices, catastrophic coverage limits, and premium subsidies for certain low-income beneficiaries.

Provides for these options to be offered through both: (1) a new Medicare part C Medicare Advantage (MA) program that integrates basic medical coverage with added prescription drug coverage, including coverage through specialized MA plans for special needs individuals; and (2) a new separate, stand-alone Medicare Prescription Drug plan (PDP) program under Medicare part D that relies on private plans to provide coverage and to bear a portion of the financial risk for drug costs.

Makes this new program effective January 1, 2006.

Provides that until this new permanent prescription drug benefit program is effective, the Secretary of Health and Human Services (HHS) shall establish a program to endorse prescription drug discount card programs in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals throughout the United States and to provide for transitional assistance for transitional assistance eligible individuals enrolled in such endorsed programs. Provides that the program shall not apply to covered discount card drugs dispensed after December 31, 2005, and transitional assistance shall be available after such date to the extent the assistance relates to drugs dispensed on or before such date.

Allows beneficiaries entitled to benefits under Medicare part A or enrolled under Medicare part B (eligible beneficiaries) to elect to enroll under new Medicare part D, and: (1) provided that they are not enrolled in an MA plan, keep their current Medicare fee-for-service coverage and receive qualified prescription drug coverage (as described below) through enrollment in Medicare part D in a new PDP that is offered in the geographic area in which the beneficiary resides; or (2) enroll in the new Medicare part C MA program in an MA plan, give up their current Medicare fee-for-service coverage, and receive qualified prescription drug coverage under the plan along with basic and possibly enhanced medical coverage through health maintenance organization (HMO) or revised MSA coverage options under the new MA program established by this Act under Medicare part C (and as otherwise provided under Medicare+Choice under Medicare part C as discussed more fully below under title II (MedicareAdvantage) of this Act).

Provides an exception for MA enrollees: (1) enrolled in MSA plans to receive qualified coverage of prescription drugs through enrollment in a PDP; (2) enrolled in private-fee-for service plans that do not provide qualified prescription drug coverage to receive qualified coverage of prescription drugs through enrollment in PDP plans; and (3) enrolled in an MA prescription drug plan (MA-PD) to receive qualified prescription drug coverage under that plan.

Directs the Secretary to establish a process for the enrollment, disenrollment, termination, and change of enrollment of Medicare part D eligible individuals in prescription drug plans. Establishes an initial enrollment period beginning November 15, 2005 .

Directs the Secretary to conduct activities designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage under Medicare part D, including information comparing the plans offered by eligible entities under Medicare part D that are available to eligible beneficiaries in an area.

Divides qualified prescription drug coverage into either a standard coverage benefit package or an alternative prescription drug coverage with at least actuarially equivalent benefits, both with access to negotiated drug prices. Outlines the standard coverage package, which includes, for 2006, a $250 deductible, 25 percent cost-sharing for drug costs between $250 and the initial coverage limit of $2,250, then no coverage; except that the beneficiary shall have access to negotiated prices, regardless of the fact that no benefits may be payable under the coverage, until incurring out-of-pocket costs for covered drugs in a year equal $3,600, with the beneficiary thereafter to pay five percent of the cost of a prescription, or a copayment of $2 for a generic drug and $5 for any other drug, whichever is greater. Includes as negotiated prices all discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations. Increases these amounts in future years by the annual percentage increase in average per capita aggregate expenditures for covered drugs for the year ending the previous July.

Includes among the out-of-pocket costs counting toward the annual $3,600 limit any costs paid by the part D eligible individual (or by another person such as a family member) under the Medicaid program or under a State pharmaceutical assistance program for which the individual (or other person) is not reimbursed.

Allows a PDP or an MA plan to provide a different prescription drug benefit design from the standard prescription drug coverage as long as the Administrator of the Medicare Benefits Administration approves of such benefit design.

Directs the Secretary to ensure that each part D eligible individual has available a choice of enrollment in at least two qualifying plans in the area in which the individual resides, at least one of which is a prescription drug plan. Provides that in such case in which such plans are not available the part D eligible individual shall be given the opportunity to enroll in a fallback prescription drug plan.

Establishes beneficiary protection requirements for qualified prescription drug plans, such as requiring each PDP sponsor offering a prescription drug plan to: (1) have a mechanism for providing specific information on a timely basis to enrollees upon request; (2) have in place with respect to covered part D drugs a cost-effective drug utilization management program and a medication therapy management program; and (3) provide that each pharmacy that dispenses a covered part D drug shall inform an enrollee of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered part D drug under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy.

Directs the Secretary to establish, and allows the Secretary to revise PDP regions in a manner that is consistent with the requirements below for the establishment and revision of MA regions, and to the extent practicable PDP regions shall be the same as MA regions. Requires a PDP sponsor to submit to the Secretary bid and other described information with respect to each prescription drug plan it offers for review by the Secretary for the purpose of conducting negotiations concerning the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan in order for the Secretary to approve or disapprove the plan. Provides that in order to promote competition under new Medicare part D and in carrying out such part, the Secretary may not interfere with the negotiations between drug

manufacturers and pharmacies and PDP sponosors and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

Establishes organizational requirements for PDP sponsors, such as licenses, and requires that they enter into a contract with the Secretary to be eligible to receive payments.

Provides for premium and cost-sharing subsidies for low-income subsidy-eligible individuals.

Provides: (1) for the establishment of risk corridors for each PDP that determines the amount of risk that the PDP shall be exposed to for drug spending, and the resultant adjustment in payment attributable to this risk; and (2) that a PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits. Prohibits adjustment in payments made by reason of this paragraph from affecting the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

Creates within the Federal Supplementary Medical Insurance Trust Fund the Medicare Prescription Drug Account for payments for low-income subsidy payments, subsidy payments, payments to qualified retiree prescription drug plans, and administrative expenses. Authorizes appropriations. Requires transfers to be made to the Medicaid account for increased administrative costs. Requires amounts withheld for late penalties to be deposited into the Fund. Requires States to make payments to the Account for dual eligibles as provided for under Medicaid.

Directs the Secretary to establish requirements for PDPs to ensure the effective coordination between a part D plan and a State Pharmaceutical Assistance Program with respect to payment of premiums and coverage and payment for supplemental prescription drug benefits for part D eligible individuals enrolled under both types of plans. Requires the Secretary to apply such coordination requirements to described Rx plans, which include Medicaid programs and group health plans and the Federal Employees Health Benefit Program (FEHBP), in the same manner as such requirements apply to a State Pharmaceutical Assistance Program.

Requires the prescription drug discount program and the transitional assistance program to be implemented by the Secretary so that interim prescription drug discount cards and transitional assistance are first available by not later than six months after the enactment of this Act in 2004 and 2005 until coverage under the new part D program becomes effective on January 1, 2006. Requires each prescription drug card sponsor that offers an endorsed discount card program to provide each discount card eligible individual entitled to benefits, or enrolled, under Medicare part A (Hospital Insurance) or part B (Supplementary Medical Insurance) with access to negotiated prices and savings on prescription drugs through enrollment in an endorsed discount card program.

Allows card sponsors to charge annual enrollment fees, not to exceed $30. Requires the fee to be uniform for all discount eligible individuals enrolled in the program. Requires a prescription drug card sponsor offering an endorsed discount card program to provide that each pharmacy that dispenses a covered discount card drug shall inform a discount card eligible individual enrolled in the program of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered discount card drug under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy.

Provides that a discount card eligible individual is an individual whose income is not more than 135 percent of the poverty line and who is entitled to have payment made of any annual enrollment fee and to have payment made, up to $600 in 2004, under such endorsed program of 90 percent of the costs incurred for covered discount card drugs.

Creates within the Federal Supplementary Medical Insurance Trust Fund the Transitional Assistance Account for

payments for transitional assistance. Makes necessary appropriations.

(Sec. 103) Establishes certain requirements for States as a condition of receiving Federal Medicaid assistance, such as requiring States to provide the Secretary with Medicaid eligibility information necessary to carry out transitional prescription drug assistance verification.

Provides for: (1) Federal phase-in of the costs of premiums and cost-sharing and cost-sharing subsidies for dually eligible individuals; and (2) coordination of Medicaid with Medicare prescription drug benefits to provide that Medicare is the primary payer for covered drugs for dual eligibles.

Exempts prices negotiated from manufacturers for discount card drugs under an endorsement card program and prices negotiated by a PDP under part D, an MA-PD plan, or a qualified retiree prescription plan from the calculation of Medicaid "best price."

Extends the Qualifying-1 (Q-1) program through September 30, 2004, and expands outreach requirements for the Commissioner of Social Security to include outreach activities for transitional assistance and low-income subsidy individuals.

(Sec. 104) Prohibits, effective January 1, 2006, the selling, issuance, or renewal of Medigap Rx policies for part D enrollees, but permits the renewal of a Medigap Rx policy that was issued before January 1, 2006. Permits persons enrolling under part D during the initial enrollment period while covered under a Medigap Rx policy to enroll in a Medigap policy without prescription drug coverage or to continue the policy in effect as modified to exclude drugs. Provides that after the end of such period the individual may continue the policy in effect subject to such modification.

Guarantees issuance of a substitute Medigap policy for persons, enrolling in part D during the initial part D enrollment period, who at the time of such enrollment were enrolled in and terminated enrollment in a Medigap policy H, I, or J or a pre-standard policy that included drug coverage. Guarantees the enrollment for any policies A, B, C, and F within the same carrier of issue. Prevents the issuer from discriminating in the pricing of such policy on the basis of such individual's health status, claims experience, receipt of health care or medical condition. Prohibits the issuer from imposing an exclusion of benefits based on a pre-existing condition under such policy. Provides that the guarantee applies for enrollments occurring in the new Medigap plan within 63 days of termination of enrollment in a Medigap plan H, I, or J.

Directs the Secretary to request the National Association of Insurance Commissioners to review and revise standards for benefit packages taking into account the changes in benefits resulting from the enactment of this Act and to otherwise update standards to reflect other changes in law included in such Act.

(Sec. 105) Includes additional provisions related to Medicare prescription drug discount cards and transitional assistance program, such as the exclusion of program costs from the calculation of the part B premium. Applies Medicare confidentiality provisions to drug pricing data.

(Sec. 106) Establishes a State Pharmaceutical Assistance Transition Commission to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs as a result of the enactment of this Act.

(Sec. 107) Requires the Secretary to study and report to Congress on variations in per capita spending for covered part D drugs among PDP regions to determine the amount of such variation that is attributable to price variations and the differences in per capita utilization that is not taken into account in the health status risk adjustment made to PDP bids.

Requires the Secretary to conduct a review of the current standards of practice, clinical services, and other service

requirements generally used for pharmacy services in long-term care settings and evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

Directs the Secretary to enter into a contract with the Institutes of Medicine of the National Academy of Science to carry out a comprehensive study for a report to Congress on drug safety and quality issues in order to provide a blueprint for a system-wide change. Authorizes appropriations.

Directs the Secretary to provide for a study and report to Congress on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under parts C and D of title XVIII on a multi-year basis.

Requires the Comptroller General to conduct a study for a report to the Congress on the extent to which drug utilization and access to covered part D drugs by subsidy eligible individuals differs from such utilization and access for individuals who would qualify as such subsidy eligible individuals except for application of the assets test.

Directs the Secretary to undertake a study for a report to Congress of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually impaired individuals.

(Sec. 108) Authorizes the Secretary to make grants to physicians for the purpose of assisting them to implement electronic prescription drug programs that comply with appropriate standards. Authorizes appropriations.

(Sec. 109) Expands the work of quality improvement organizations to include part C and part D. Requires such organizations to offer providers, practitioners, MA organizations, and PDP sponsors quality improvement assistance pertaining to prescription drug therapy.

Directs the Secretary to request the Institute of Medicine of the National Academy of Sciences to conduct an evaluation of the peer review program under SSA title XI.

(Sec. 110) Directs the Federal Trade Commission to conduct a study for a report to Congress on differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers.

(Sec. 111) Directs the Comptroller General of the United States to conduct an initial and final study for a report to Congress on trends in employment-based retiree health coverage, including coverage under FEHBP, and the options and incentives available under this Act which may have an effect on the voluntary provision of such coverage.

Title II: Medicare Advantage - Subtitle A: Implementation of Medicare Advantage Program - (Sec. 201) Amends SSA title XVIII part C (Medicare+Choice) to replace the current Medicare+Choice program with the Medicare Advantage (MA) program.

Subtitle B: Immediate Improvements - (Sec. 211) Revises the payment system, requiring all plans to be paid at a rate at least as high as the rate for traditional Medicare fee-for-service plans. Makes change in budget neutrality for blend. Increases minimum percentage increase to national growth rate. Includes costs of Department of Defense and Department of Veterans Affairs military facility services to Medicare-eligible beneficiaries in calculation of payment rates.

Directs the Medicare Payment Advisory Commission (MEDPAC) to conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC).

Requires the Secretary to submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts on the availability on Medicare Advantage plans in different areas and its impact on lowering

premiums and increasing benefits under such plans.

Requires a Medicare Payment Advisory Commission (MEDPAC) study and report to Congress with respect to authority regarding disapproval of unreasonable beneficiary cost-sharing.

Subtitle C: Offering of Medicare Advantage (MA) Regional Plans; Medicare Advantage Competition - (Sec. 221) Directs the Secretary to establish regional plans to encourage private plans to serve Medicare beneficiaries in from ten to 50 regions, including in rural areas, within the 50 States and the District of Columbia beginning not later than January 1, 2005.

Prohibits the Secretary from offering a local preferred provider organization plan under Medicare part C during 2006 or 2007 in a service area unless such plan was offered under such part (including under a demonstration project under such part) in such area as of December 31, 2005. Includes risk corridors for plans during the first two years of the program in 2006 and 2007; a stabilization fund to encourage plan entry and limit plan withdrawals; a blended benchmark that will allow plan bids to influence the benchmark amount; and network adequacy stabilization payments to assist plans in forming adequate networks, particularly in rural areas.

(Sec. 222) Provides that beginning in 2006, each MA organization shall submit to the Secretary for each MA plan for the service area in which it intends to be offered in the following year the monthly aggregate bid amount for the provision of all items and services under the plan for the type of plan and year involved.

Requires this monthly bid amount, with respect to which the Secretary has authority to negotiate, to be compared against respective benchmark amounts for MA local and MA regional plans, with plans that submit bids below the benchmark to be paid their bids, plus 75 percent of the difference between the benchmark and the bid which must be returned to beneficiaries in the form of additional benefits or reduced premiums. Provides that for plans that bid above the benchmark the government will pay the benchmark amount, and the beneficiary will pay the difference between the benchmark and the bid amount as a premium.

Requires the MA plan to provide an enrollee a monthly rebate equal to 75 percent of any average per capita savings as applicable to the plan and year involved. Allows the beneficiary rebate to be credited toward the provision of supplemental health care benefits, the prescription drug premium, or the Medicare part B premium. Requires the plan to disclose to the Secretary information on the form and amount of the rebate or the actuarial value in the case of supplemental health care benefits. Provides that for MA plans providing rebates the MA monthly basic beneficiary premium will be zero.

Provides that: (1) for MA plans with bids above the applicable benchmark, the MA monthly basic beneficiary premium will equal the amount by which the bid exceeds the benchmark; (2) the MA monthly prescription drug beneficiary premium is the base beneficiary premium less the amount of rebate credited toward such amount; and (3) the MA monthly supplemental beneficiary premium means the portion of the aggregate monthly bid amount for the year that is attributable to the provision of supplemental health benefits, less the amount of rebate credited toward such portion.

Allows enrollees to have their MA premiums deducted directly from their social security benefits, through an electronic funds transfer, or such other means as specified by the Secretary. Requires all premium payments withheld to be credited to the appropriate Trust Fund (or Account therof), as specified by the Secretary, and paid to the MA organization involved.

Subtitle D: Additional Reforms - (Sec. 231) Allows specialized MA plans for special needs individuals to be any type of

coordinated care plan. Designates two specific segments of the Medicare population as special needs beneficiaries, but also provides the Secretary the authority to designate other chronically ill or disabled beneficiaries as special needs beneficiaries. Permits certain restriction on enrollment for specialized MA plans for special needs individuals. Provides authority to designate other plans as specialized MA plans.

(Sec. 232) Establishes that the MA program is a Federal program operated under Federal rules. Provides that State laws do not apply except State licensing laws or State laws relating to plan solvency.

(Sec. 233) Makes the Medicare Medical Savings Account (MSA) demonstration program a permanent program option and eliminates the capacity limit and the deadline for enrollment. Provides that non-contract providers furnishing services to enrollees of MSAs will be subject to the same balanced billing limitations as non-contract providers furnishing services to enrolleees of coordinated care plans. Eliminates requirements for the Secretary to submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted.

(Sec. 234) Allows a reasonable cost reimbursement contract to operate indefinitely unless two other plans of the same type enter the cost contract's service area. Requires these two other plans to meet the following minimum enrollment requirements: (1) at least 5,000 enrollees for the portion of the area that is within a metropolitan statistical area having more than 250,000 people and counties contiguous to such an area; and (2) at least 1,500 enrollees for any other portion of such area.

(Sec. 235) Amends the Consolidated Omnibus Budget Reconciliation Act of 1985 to extend Municipal Health Services Demonstration projects through December 31, 2006, for beneficiaries who reside in the city in which the project is operated.

(Sec. 236) Amends SSA title XVIII to provide that protections against balance billing apply to PACE providers and beneficiaries enrolled with such PACE providers in the same manner as such protections apply to any individual enrolled with a Medicare +Choice organization under part C or with an eligible organization.

Provides that MA provisions relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under Medicare shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as provisions apply to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to under such provisions.

Amends SSA title XIX (Medicaid) to provide that, with respect to services covered under the State plan but not under Medicare that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan.

(Sec. 237) Provides that Federally Qualified Heatlh Centers (FQHCs) will receive a wrap-around payment for the reasonable costs of care provided to Medicare managed care patients served at such centers. Raises reimbursements to FQHCs in order that when they are combined with MA payments and cost-sharing payments from beneficiaries they equal 100 percent of the reasonable costs of providing such services. Extends the safe harbor to include any remuneration between a FQHC (or entity controlled by an FQHC) and an MA organization.

(Sec. 238) Requires the Secretary to enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation (for the Secretary and Congress) of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the Medicare program.

Subtitle E: Comparative Cost Adjustment (CCA) Program - (Sec. 241) Directs the Secretary to establish a program for the application of comparative cost adjustment in CCA areas, to begin January 1, 2010, and last six years, and to test whether direct competition between private plans and the original Medicare fee-for-service program will enhance competition in Medicare.

Title III: Combatting Waste, Fraud, and Abuse - (Sec. 301) Amends SSA title XVIII to allow the Secretary to make a conditional Medicare payment if a primary plan has not made or cannot reasonably be expected to make prompt payment. Requires the payment to be contingent on reimbursement by the primary plan to the appropriate Medicare trust fund. Requires a primary plan as well as an entity that receives payment from a primary plan to reimburse the Medicare Trust Funds for any payment made by the Secretary if the primary plan was obligated to make payment. Makes other changes with regard to Medicare as a secondary payer to address the Secretary's authority to recover payment from any and all responsible entities and to bring action, including the collection of double damages, to recover payment under the Medicare secondary payer provisions.

(Sec. 302) Directs the Secretary to establish and implement quality standards for suppliers of items and services of durable medical equipment, prosthetics and orthotics, and certain other items and services. Requires the Secretary to establish standards for clinical conditions for payment for items of durable medical equipment.

Replaces the current demonstration projects for competitive acquisition of items and services with a permanent program requiring the Secretary to establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing of competitively priced described items and services (including durable medical equipment and medical supplies) for which payment is made under Medicare part B. Allows such areas to differ for different items and services.Allows the Secretary to exempt from such programs rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service and items and services for which the application of competitive acquisition is not likely to result in significant savings.Requires payment under Medicare part B for competitively priced items and services to be based on bids submitted and accepted for such items and services, and based on such bids the Secretary shall determine a single payment amount for each item or service in each competitive acquisition area. Requires Medicare payment to be equal to 80 percent of the payment amount determined, with beneficiaries paying the remaining 20 percent (after meeting the part B deductible).

Directs the Secretary to conduct a demonstration project on the application of competitive acquisition to clinical diagnostic laboratory tests.

Requires the Comptroller General to conduct a study for a report to Congress on the impact of competitive acquisition of durable medical equipment on suppliers and manufacturers of such equipment and on patients.

Provides that for durable medical equipment, prosthetic devices, prosthetics and orthotics, the update will be 0 points in 2004 through 2008, and that after 2008 for those items not included in competitive bidding the update will be the consumer price index.

Provides that for 2005 the payment amount for certain items, oxygen and oxygen equipment, standard wheelchairs,

nebulizers, diabetic lancets and testing strips, hospital beds and air mattresses, will be reduced.

Provides that for prosthetic devices and orthotics and prosthetics in 2004, 2005, and 2006, the update will be 0 percentage points and for a subsequent year is equal to the percentage increase in the consumer price index for all urban customers for the 12-month period ending in June of the previous year.

Directs the Inspector General of the Department of Health and Human Services to conduct a study for a report to Congress to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under Medicare are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability.

(Sec. 303) Amends SSA title XVIII to: (1) require the Secretary, beginning in 2004, to make adjustments in practice expense relative value units for certain drug administration services when establishing the physician fee schedule; (2) require the Secretary to use the survey data submitted to the Secretary as of January 1, 2003, by a certain physician speciality organization; and (3) require the Secretary, beginning in 2005, to use supplemental survey data to adjust practice expense relative value units for certain drug administration services in the physician fee schedule if that supplemental survey data includes information on the expenses associated with administering drugs and biologicals the administration of drugs and biologicals, the survey meets criteria for acceptance, and the survey is submitted by March 1, 2004, for 2005, or March 1, 2005, for 2006. (States that this latter provision shall apply only to a speciality that receives 40 percent or more of its Medicare payments in 2002 from drugs and biologicals and shall not apply with respect to the survey submitted by a certain physician speciality organization.) Exempts the adjustments in practical expense relative value units for certain drug administration services from the budget neutrality requirements in 2004.

Requires the Secretary to: (1) promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption; (2) make adjustments to the nonphysician work pool methodology for the determination of practice expense relative value units under the physician fee schedule so that practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of services not determined under such methodology; and (3) review and appropriately modify Medicare's payment policy in effect on October 1, 2003, for the administration of more than one drug or biological to an individual on a single day through the push technique. Makes the increase in expenditures resulting from this provision exempt from the budget-neutrality requirement in 2004.

Requires a transitional adjustment or additional payment for services furnished from January 1, 2004, through December 31, 2005, to be made for drug administration services. Requires the part B payment to be made to the physician and equal a percentage of the payment otherwise made.

Directs the MEDPAC to review the payment changes made under this section insofar as they affect payments under Medicare part B for items and services furnished by oncologists and for drug administration services furnished by other specialists. Requires MEDPAC to submit a report to the Secretary and Congress and for the Secretary to make appropriate payment adjustments on the basis of such report.

Provides that the following drugs and biologicals are to be paid at 95 percent of the average wholesale price (AWP): (1) a drug or biological furnished before January 1, 2004; (2) blood clotting factors furnished during 2004; (3) a drug or biological furnished during 2004 that was not available for part B payment as of April 1, 2003; (3) pneumoccal influenza and hepatitis B vaccines furnished on or after January 1, 2004; and (4) a drug or biological furnished during 2004 in

connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities. Provides in general that payments for other drugs furnished in 2004 will equal 85 percent of the AWP (determined as of April 1, 2003). Provides that, beginning in 2005, drugs or biologicals, except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services, will be paid using either the average sales price methodology or through the competitive acquisition program. Provides that infusion drugs furnished through covered durable medical equipment starting January 1, 2004, will be paid at 95 percent of the AWP in effect on October 1, 2003, and that those infusion drugs which may be furnished in a competitive area starting January 1, 2007, will be paid at the competitive price. Provides that intravenous immune globulin will be paid at 95 percent of the AWP in 2004 and paid according to the average sales price method in 2005.

Authorizes the Secretary to substitute a different percent of the April 1, 2003 AWP, but not less than 80 percent.

Establishes the use of the average sales price methodology for payment for drugs and biologicals (except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services) that are furnished on or after January 1, 2005. Creates an exception to this methodology in the case of a physician who elects to participate in the newly established competition acquisition program.

Directs the Inspector General of the Department of Health and Human Services to conduct studies to determine the widely available market prices of drugs and biologicals.

Directs the Secretary to conduct a study for a report to Congress on sales of drugs and biologicals to large volume purchasers for purposes of determining whether the price at which such drugs and biologicals are sold to such purchasers does not represent the price such drugs and biologicals are made available for purchase to prudent investors.

Directs the Inspector General to conduct a study for a report to Congress on adequacy of reimbursement rate under average sales price methodology.

Directs the Secretary to establish and implement a competitive acquisition program to acquire and pay for competitively biddable drugs and biologicals through the establishment of competitive acquisition areas for the award of contracts. Gives each physician the opportunity annually to elect to obtain drugs and biologicals under the program, rather than the program above using average sales methodology. Directs the Secretary to begin to phase-in the program beginning in 2006.

(Sec. 304) Makes the amendments applicable above applicable to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology.

(Sec. 305) Amends SSA title XVIII to provide that in the case of inhalation drugs or biologicals furnished through covered durable medical equipment that are furnished in 2004, the payment amount will be at 85 percent of AWP, and in 2005 and subsequent years, the payment amount will be the amount provided under the average sales price methodology.

Directs the Comptroller General to conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program for a report to Congress.

(Sec. 306) Requires the Secretary to conduct a demonstration project to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recoupoing overpayments under the Medicare program for services for which payment is made under Medicare part A or part B.

Requires a report to Congress on the demonstration program.

(Sec. 307) Directs the Secretary to establish a pilot program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees. Makes necessary appropriations.

Title IV: Rural Provisions - Subtitle A: Provisions Relating to Part A Only - (Sec. 401) Amends SSA title XVIII part A to require Medicare, for discharges during a fiscal year beginning with FY 2004, to direct the Secretary to compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year for hospitals located in a large urban area (or, beginning with FY 2005, for all hospitals in the previous year) increased by the applicable percentage increase. Directs the Secretary to compute, for discharges occuring in a fiscal year beginning with 2004, an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed for FY 2003 for hospitals in a large urban area (or, beginning with FY 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase for the year involved.

(Sec. 402) Provides that for discharges after April 1, 2004, a hospital that is not a large urban hospital that qualifies for a disproportionate share (DSH) adjustment will receive its DSH payments using the current DSH adjustment formula for large urban hospitals, subject to a limit. Caps the DSH adjustment formula at 12 percent for any of these hospitals except rural referral centers.

(Sec. 403) Provides that for discharges on or after October 1, 2004, the Secretary is required to decrease the labor-related share to 62 percent of the standardized amount when such change results in higher total payments to the hospital. Provides that for discharges occurring on or after October 1, 2004, the Secretary is also required to decrease the labor-related share to 62 percent of the standardized amount for hospitals in Puerto Rico when such change results in higher total payments to the hospital.

(Sec. 404) Directs the Secretary, after revising the market basket weights to reflect the most current data, to establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every five years. Requires the Secretary to include in the publication of the final rule for payment for inpatient hospital services for FY 2006, an explanation of the reasons for, and options considered, in determining such frequency.

(Sec. 405) Reimburses inpatient, outpatient, and covered skilled nursing facility services provided by a critical access hospital (CAH) at 101 percent of reasonable costs of services furnished to Medicare beneficiaries.

Expands reimbursement of on-call emergency room providers to include physician's assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services provided on or after January 1, 2005.

Allows an eligible CAH to be able to receive payments made on a periodic interim payment (PIP) basis for its inpatient services. Requires the Secretary to develop alternative methods for the timing of PIP payments to the CAHs.

Prohibits the Secretary from requiring that all physicians or practitioners providing services in a CAH assign their billing rights to the entity in order for the CAH to be paid on the basis of 115 percent of the fee schedule for any individual physician or practitioner who did not assign billing rights to the CAH. Prohibits a CAH from receiving payment based on 115 percent of the fee schedule for any individual physician or practitioner who did not assign billing rights to the CAH.

Allows a CAH to operate up to 25 beds while deleting the requirement that only 15 of the 25 beds be used for acute care at any time.

Establishes an authorization to award rural hospital flexibility grants at $35 million each year from FY 2005 through FY 2008 and in subsequent years requires a State to consult with the hospital association and rural hospitals in the State on the most appropriate way to use such funds. Prohibits a State from spending more than the lesser of 15 percent of the grant amount for administrative expenses or the State's federally negotiated indirect rate for administering the grant. Provides that in FY 2005 up to five percent of the total amount appropriated for grants will be available to the Health Resources and Services Administration for administering such grants.

Permits a CAH to establish a distinct part psychiatric or rehabilitation unit that meets the applicable requirements that would otherwise apply to the distinct part if the distinct part were established by a "subsection (d) hospital." Limits the total number of beds that may be established for a distinct part unit to no more than ten. Provides that if a distinct part unit does not meet the applicable requirements during a cost reporting period then no Medicare payment will be made to the CAH for services furnished in such unit during such period. Requires Medicare payments to resume only after the CAH demonstrates that the requirements have been met. Requires Medicare payments for services provided in the distinct part units to equal the amount of the payments that would otherwise be made on a prospective payment basis to distinct part units of a CAH.

Allows certain milage standards to be waived in the case of a facility that was designated as a CAH before January 1, 2006 and was certified by the State as being a necessary provider of health care services.

(Sec. 406) Requires the Secretary to provide for an additional payment amount to each low-volume hospital for discharges occurring during a fiscal year beginning with FY 2005.

(Sec. 407) Provides that in no case will a hospital be denied treatment as a sole community hospital or payment because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances so long as data from at least one applicable base cost reporting period is available.

(Sec. 408) Expands the definition of attending physician in hospice to include a nurse practitioner.

(Sec. 409) Directs the Secretary to conduct a demonstration project for the delivery of hospice care to Medicare beneficiaries in rural areas. Provides that under the project Medicare beneficiaries who are unable to receive hospice care in the facility for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs.

(Sec. 410) Excludes certain rural health clinic and Federally-qualified health center services from the prospective payment system for skilled nursing facilities.

(Sec. 410A) Directs the Secretary to establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries.

Subtitle B: Provisions Relating to Part B Only - (Sec. 411) Extends until January 1, 2006 the hold harmless provisions governing hospital outpatient department (OPD) reimbursement for small rural hospitals and sole community hospitals.

Requires the Secretary to conduct a study to determine if the costs incurred by hospitals located in rural areas by ambulatory payment classification groups exceed those costs incurred by hospitals located in urban areas. Provides that if appropriate the Secretary is required to provide for a payment adjustment to reflect the higher costs of rural providers

by January 1, 2006.

(Sec. 412) Directs the Secretary to increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00 for services furnished on or after January 1, 2004, and before January 1, 2007.

(Sec. 413) Establishes a new five percent incentive payment program designed to reward both primary care and specialist care physicians for furnishing physicians' services on or after January 1, 2005, and before January 1, 2008 in physician scarity areas.

Directs the Secretary to pay the current law ten percent Health Professional Shortage Area (HPSA) incentive payment for services furnished in full county primary care geographic area HPSAs automatically rather than having the physician identify the health professional shortage area involved.

Directs the Comptroller General to conduct a study for a report to Congress on the differences in payment amounts under the Medicare physician fee schedule for physicians' services in different geographic areas.

(Sec. 414) Revises payment for ambulance services to provide for, when phasing in the application of the payment rates under the fee schedule, for each level of ground service furnished in a year, for the portion of the payment amount that is based on the fee schedule to be the greater of the amount determined under such national fee schedule or a blended rate of the national fee schedule and the regional fee schedule for the region involved, whichever resulted in a larger payment, with the blended rate to be based 100 percent on the national fee schedule.

Requires the Secretary to establish a regional fee schedule for each of the nine census divisions. Provides for adjustment in payment for certain long trips. Directs the Secretary to provide for a percentage increase in the base rate of the fee schedule for ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010 that originate in a qualified rural area. Increases by two percent the payments for ground ambulance services orginating in a rural area or a rural census tract for services furnished on or after July 1, 2004, and before January 1, 2007. Provides that the fee schedule for ambulances in other areas will by increased by one percent. Provides that these increased payments will not affect Medicare payments for covered ambulance services after 2007.

Requires the Comptroller General to submit to Congress a report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the Medicare ambulance fee schedule.

(Sec. 415) Provides that the regulations governing the use of ambulance services will provide that, to the extent that any ambulance service (whether ground or air) may be covered, that a rural air ambulance service will be reimbursed at the air ambulance rate if: (1) the air ambulance service is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and (2) the air ambulance service complies with the equipment and crew requirements established by the Secretary.

(Sec. 416) Provides that hospitals with fewer than 50 beds in qualified rural areas will receive 100 percent reasonable cost reimbursement for clinical diagnostic laboratory tests covered under Medicare part B that are provided as outpatient hospital services during a cost reporting period beginning during the two year period beginning on July 1, 2004.

(Sec. 417) Amends the Balanced Budget Act of 1997 to extend the telemedicine demonstration project by 4 years and to increase total funding for the project.

(Sec. 418) Directs the Secretary to evaluate demonstration projects conducted by the Secretary under which skilled

nursing facilities are treated as originating sites for telehealth services for a report to Congress.

Subtitle C: Provisions Relating to Parts A and B - (Sec. 421) Provides that with respect to episodes and visits on or after April 1, 2004, and before April 1, 2005, in the case of home health services furnished in a rural area, the Secretary is required to increase the payment amount otherwise made for such services by five percent. Prevents such temporary additional payment increase from being used in calculating future home health payment amounts.

(Sec. 422) Provides that a teaching hospital's total number of Medicare-reimbursed resident positions will be reduced for cost reporting periods starting July 1, 2005, if its reference resident level is less than its applicable resident limit. Exempts rural rural hospitals with fewer than 250 acute care inpatient beds from such reduction. Provides that for such other hospitals the reduction will equal 75 percent of the difference between the hospital's limit and its reference resident level. Authorizes the Secretary to increase the applicable resident limit for each qualifying applicant hospital by such numbers as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005.

Subtitle D: Other Provisions - (Sec. 431) Amends SSA title XI to provide that any remuneration in the form of a contract, lease, grant, loan, or other agreement between a public or non-profit private health center and an individual or entity providing goods or services to health center would not be a violation of the anti-kickback statue if such agreement contributes to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population.

(Sec. 432) Amends SSA title VII to expand the functions of the Office of Rural Health Policy to include administering grants, cooperative agreements, and contracts to provide technical assistance and other necessary activities to support activities related to improving health care in rural areas.

(Sec. 433) Directs MEDPAC to conduct a study of specified rural provisions of this title for various reports to Congress.

(Sec. 434) Directs the Secretary to waive such provisions of the Medicare program as are necessary to conduct a demonstration project under which frontier extended stay clinics in isolated rural areas are treated as providers of items and services under the Medicare program. Authorizes appropriations.

Title V: Provisions Relating to Part A - Subtitle A: Inpatient Hospital Services - (Sec. 501) Amends SSA title XVIII with respect to hospital payment updates to provide that: (1) an acute hospital will receive an update of the market basket from FY 2005 through FY 2007 if it submits data on the ten quality indicators established by the Secretary as of November 1, 2003; and (2) an acute hospital that does not submit data to the Secretary will receive an update of the market basket percentage minus 0.4 percentage points for the fiscal year in question and that the Secretary will not take this reduction into account when computing the applicable percentage increase in subsequent years.

Directs the Comptroller General to conduct a study to determine: (1) the appropriate level and distribution of Medicare payments in relation to costs for short-term general hospitals under the inpatient prospective payment system; and (2) the need for geographic adjustments to reflect legitmate differences in hospital costs across different geographic areas, kinds of hospitals, and types of cases.

(Sec. 502) Expands the formula for determining the indirect medical education adjustment percentage to cover the period from April 1, 2004 to on and after October 1, 2007.

(Sec. 503) Requires the Secretary to add new diagnosis and procedure codes in April 1 of each year without requiring the Secretary to adjust the payment (or diagnosis-related group classification) until the fiscal year that begins after such date.

Requires the Secretary when establishing whether diagnosis related group (DRG) payment is adequate to apply a threshold that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between costs and charges) or 75 percent of one standard deviation for the diagnosis-related group involved. Requires the mechanism established to recognize the costs of new medical services and technologies under the appropriate Medicare payment system to be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under Medicare part A (Hospital Insurance).

Directs the Secretary, before establishing any add-on payment with respect to a new technology, to seek to identify one or more diagnosis-related groups associated with such technology and, within such groups, the Secretary is required to assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. Prohibits the making of an add-on payment in such case. Provides that funding for new technology will no longer be budget neutral.

(Sec. 504) Provides that hospitals in Puerto Rico will receive Medicare payments based on a 50-50 split between Federal and local amounts before April 1, 2004. Provides that starting April 1, 2004 through September 30, 2004, payment will be based on a 62.5 percent Federal amount and a 37.5 percent local amount, and that starting October 1, 2004, payment will be based on a 75 percent Federal amount and a 25 percent local amount.

(Sec. 505) Directs the Secretary to establish a process and payment adjustment to recognize commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.

(Sec. 506) Requires that hospitals that participate in Medicare and that provide Medicare covered inpatient hospital services under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, an Indian tribal organization, or an urban Indian organization be paid in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodologies, and rates of payment. Requires that these rates of payment must be accepted as payment in full for the items and services provided.

(Sec. 507) Modifies the "whole hospital" exception to the prohibition against physicians referring Medicare patients to entities in which they or their immediate family members have financial interests to provide for a period of 18 months from the date of enactment of this Act during which there is excluded from such exception (and thereby subjected to the prohibition) those circumstances in which a physician's ownership interest is in a "subsection d hospital"devoted primarily or exclusively to cardiac, orthopedic, surgical, or other specialties designated by the Secretary. Exempts from such provision speciality hospitals in operation or under development as of November 18, 2003.

Requires that, in order to maintain the exception, the speciality hospital may not increase the number of physician investors as of November 18, 2003; change or expand the field of specialization it treats; expand beyond the main campus; or increase the total number of beds in its facilities by more than the greater of five beds or 50 percent of the number of beds in the hospital as of November 18, 2003.

Makes a similar modification with respect to the rural provider exception.

Directs the Secretary in determining whether a hospital is under development as of November 18, 2003 to consider whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received, and other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

Directs MEDPAC to conduct a study to determine: (1) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups; (2) the extent to which speciality hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection; (3) the financial impact of physician-owned specialty hospitals on local full-service community hospitals; (4) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and (5) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

Directs the Secretary to conduct a study of a representative sample of specialty hospitals to: (1) determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest; (2) determine the referral patterns of physician owners; (3) compare the qualty of care furnished in physician-owned speciality hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and (5) assess the differences in uncompensated care between the specialty hospital and local full-service community hospitals, and the value of any tax exemption availabble to such hospitals.

(Sec. 508) Directs the Secretary to establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State to which to be reclassified. Provides that a qualifying hospital (which must be a "subsection (d) hospital" is not eligible for a change in wage index classification on the basis of distance or commuting. Requires the qualifying hospital to meet such other criteria, such as quality, as the Secretary may specify by instruction or otherwise. Provides that if the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital, the hospital shall be reclassified to the area selected. Requires such reclassification to apply with respect to discharges occurring during the three year period beginning with April 2, 2004. Limits the total aggregate amount of additional expenditures resulting from application of this paragraph to $900 million.

Subtitle B: Other Provisions - (Sec. 511) Increases the per diem RUG payment for a skilled nursing facility (SNF) resident with acquired immune deficiency syndrome (AIDS). Provides that such payment increase will not apply on and after such date when the Secretary certifies that the SNF case mix adjustment adequately compensates for the facility's increased costs associated with caring for a resident with AIDS.

(Sec. 512) Provides coverage of certain physician's services for certain terminally ill individuals who have not elected the hospice benefit and have not previously received these physician's services.

(Sec. 513) Directs the Comptroller General to conduct a study of portable diagnostic ultrasound services furnished to Medicare beneficiaries in SNFs for a report to Congress.

Title VI: Provisions Relating to Part B - Subtitle A: Provisions Relating to Physicians' Services - Amends SSA title XVIII with respect to payment for physicians' services to: (1) provide that the update to the conversion factor for 2004 and 2005 will not be less than 1.5 percent; (2) modify the formula for calculating the sustainable growth rate to provide that the gross domestic product factor will be based on the annual average change over the preceding 10 years (a 10-year rolling average); (3) provide that in calendar years 2004 and 2005, for physicians's services provided in Alaska, the Secretary is required to increase geographic practice cost indices to a level of 1.67 for each of the work, practice expense, and malpractice cost indices that would otherwise be less than 1.67; and (4) allow podiatrists, dentists, and optometrists to enter into private contracts with Medicare beneficiaries.

(Sec. 604) Directs the Comptroller General to conduct a study for a report to Congress on access of Medicare beneficiaries to physicians's services under the Medicare program.

(Sec. 605) Requires the Secretary to review and consider alternative data sources than those currently used to establsih the geographic index for the practice expense component under the Medicare physician fee schedule no later than January 1, 2005. Requires the Secretary to select two physician payment localties for such p

Actions Timeline

- **Dec 8, 2003:** Signed by President.
- **Dec 8, 2003:** Signed by President.
- **Dec 8, 2003:** Became Public Law No: 108-173.
- **Dec 8, 2003:** Became Public Law No: 108-173.
- **Dec 7, 2003:** Presented to President.
- **Dec 7, 2003:** Presented to President.
- **Nov 25, 2003:** Conference report considered in Senate. (consideration: CR S15882-15915)
- **Nov 25, 2003:** Conference report agreed to in Senate: Senate agreed to conference report by Yea-Nay Vote. 54 - 44. Record Vote Number: 459.
- **Nov 25, 2003:** Senate agreed to conference report by Yea-Nay Vote. 54 - 44. Record Vote Number: 459.
- **Nov 25, 2003:** Message on Senate action sent to the House. (text as passed Senate: CR S15915)
- **Nov 24, 2003:** Conference report considered in Senate. (consideration: CR S15670-15771)
- **Nov 24, 2003:** Cloture Motion on conference report to accompany H.R. 1 invoked in Senate by Yea-Nay Vote. 70 - 29. Record Vote Number: 457.
- **Nov 24, 2003:** Point of order with respect to conference report to accompany H.R. 1 raised in Senate.
- **Nov 24, 2003:** Motion to waive the Budget Act with respect to the measure (the conference report to accompany H.R.1) made in Senate.
- **Nov 24, 2003:** Motion to waive the Budget Act with respect to the measure (conference report to accompany H.R. 1) agreed in Senate by Yea-Nay Vote. 61 - 39. Record Vote Number: 458.
- **Nov 24, 2003:** Point of order fell when the motion to waive the Budget Act was agreed to in Senate.
- **Nov 23, 2003:** Conference report considered in Senate. (consideration: CR S15592-15644)
- **Nov 22, 2003:** The previous question was ordered without objection.
- **Nov 22, 2003:** Mr. Turner (TX) moved to recommit with instructions to the conference committee.
- **Nov 22, 2003:** On motion to recommit with instructions to conference committee Failed by recorded vote: 211 - 222 (Roll No. 668).
- **Nov 22, 2003:** Conference report agreed to in House: On agreeing to the conference report Agreed to by the Yeas and Nays: 220 - 215 (Roll No. 669).
- **Nov 22, 2003:** On agreeing to the conference report Agreed to by the Yeas and Nays: 220 - 215 (Roll No. 669).
- **Nov 22, 2003:** Mr. Thomas moved to reconsider the vote.
- **Nov 22, 2003:** Mr. DeLay moved to table the motion to reconsider. (consideration: CR 11/21/2003 H12296-12297)
- **Nov 22, 2003:** On motion to table the motion to reconsider Agreed to by the Yeas and Nays: 210 - 193 (Roll No. 670).
- **Nov 22, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Nov 22, 2003:** Conference papers: message on House action held at the desk in Senate.
- **Nov 22, 2003:** Conference report considered in Senate. (consideration: CR S15519-15533, S15533-15569, S15574-15588)
- **Nov 22, 2003:** Cloture motion on the conference report to accompany H.R. 1 presented in Senate.
- **Nov 21, 2003:** Conference report filed: Conference report H. Rept. 108-391 filed.(text of conference report: CR 11/20/2003 H11877-12103)
- **Nov 21, 2003:** Conference report H. Rept. 108-391 filed. (text of conference report: CR 11/20/2003 H11877-12103)
- **Nov 21, 2003:** Conference papers: Senate report and manager's statement held at the desk in Senate.
- **Nov 21, 2003:** Conference committee actions: Conferees agreed to file conference report.
- **Nov 21, 2003:** Conferees agreed to file conference report.
- **Nov 21, 2003:** Rules Committee Resolution H. Res. 463 Reported to House. Rule provides for consideration of the conference report to H.R. 1 with 1 hour of general debate.
- **Nov 21, 2003:** Rule H. Res. 463 passed House.
- **Nov 21, 2003:** Mr. Thomas brought up conference report H. Rept. 108-391 for consideration under the provisions of H. Res. 463. (consideration: CR H12247-12297)
- **Nov 21, 2003:** DEBATE - Pursuant to a previous order of the House, the House proceeded with two hours of debate on the conference report to accompany H.R. 1.
- **Nov 20, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 201 - 222 (Roll no. 650). (consideration: CR H11678-11679)

Nov 20, 2003: Motion to reconsider laid on the table Agreed to without objection.

- **Nov 20, 2003:** Mr. Inslee moved that the House instruct conferees. (consideration: CR H11845-11853; text: CR H11845)
- **Nov 20, 2003:** DEBATE - The House proceeded with one hour of debate on the Inslee motion to instruct conferees on H.R. 1.
- **Nov 19, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 203 - 218 (Roll no. 637). (consideration: CR H11553)
- **Nov 19, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Nov 19, 2003:** Ms. Hooley (OR) moved that the House instruct conferees. (consideration: CR H11598-11605; text: CR H11598)
- **Nov 19, 2003:** DEBATE - The House proceeded with one hour of debate on the Hooley motion to instruct conferees on H.R. 1.
- **Nov 19, 2003:** DEBATE - The House continued with debate on the Hooley motion to instruct conferees on H.R. 1.
- **Nov 18, 2003:** Ms. Berkley moved that the House instruct conferees. (consideration: CR 11/19/2003 H11493-11500; text: CR 11/19/2003 H11493)
- **Nov 18, 2003:** DEBATE - The House proceeded with one hour of debate on the Berkley motion to instruct conferees on H.R. 1.
- **Nov 18, 2003:** The previous question was ordered without objection.
- **Nov 18, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion of debate on the Berkley motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote, announced that the ayes had prevailed. Ms. Berkley demanded the yeas and nays and the Chair postponed further proceedings on the question until Wednesday, November 19, 2003.
- **Nov 7, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 184 - 207 (Roll no. 619). (consideration: CR H11009-11010)
- **Nov 7, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Nov 6, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 197 - 209 (Roll no. 615). (consideration: CR H10512)
- **Nov 6, 2003:** Mr. Cardoza moved that the House instruct conferees. (consideration: CR H10528-10534; text: CR H10528)
- **Nov 6, 2003:** DEBATE - The House proceeded with one hour of debate on the Cardoza motion to instruct conferees.
- **Nov 6, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion of debate on the Cardoza motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote, announced that the noes had prevailed. Mr. Cardoza demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Nov 5, 2003:** Mrs. Capps moved that the House instruct conferees. (consideration: CR H10438-10443; text: CR H10438)
- **Nov 5, 2003:** DEBATE - The House proceeded with one hour of debate on the Capps motion to instruct conferees on H.R. 1.
- **Nov 5, 2003:** The previous question was ordered without objection.
- **Nov 5, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion of debate on the Capps motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote, announced that the noes had prevailed. Mrs. Capps demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Oct 30, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 195 - 217 (Roll no. 599). (consideration: CR 10/31/2003 H10210-10211)
- **Oct 30, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Oct 29, 2003:** Mr. Davis (FL) moved that the House instruct conferees. (consideration: CR H10106-10112; text: CR H10106)
- **Oct 29, 2003:** DEBATE - The House proceeded with one hour of debate on the Davis (FL) motion to instruct conferees.
- **Oct 29, 2003:** The previous question was ordered without objection.
- **Oct 29, 2003:** POSTPONED ROLL CALL VOTES - At the conclusion of debate on the Davis (FL) motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote, announced that the noes had prevailed. Mr. Davis (FL) demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Oct 28, 2003:** On motion to instruct conferees Failed by the Yeas and Nays: 194 - 209 (Roll no. 573). (consideration:

CR H9967)

- **Oct 21, 2003:** Mr. Brown (OH) moved that the House instruct conferees. (consideration: CR H9780-9784)
- **Oct 21, 2003:** DEBATE - The House proceeded with one hour of debate on the Brown (OH) motion to instruct conferees on H.R. 1.
- **Oct 21, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion of debate on the Brown (OH) motion to instruct conferees, the Speaker put the question on adoption of the motion and by voice vote, announced that the noes had prevailed. Mr. Brown demanded the yeas and nays and the Speaker postponed further proceedings on the adoption of the motion until a later time.
- **Oct 15, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 190 - 218 (Roll no. 542). (consideration: CR H9441-9442)
- **Oct 15, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Oct 8, 2003:** Ms. Schakowsky moved that the House instruct conferees. (consideration: CR H9349-9354; text: CR H9349)
- **Oct 8, 2003:** DEBATE - The House proceeded with one hour of debate on the Schakowsky motion to instruct conferees which was noticed in the Congressional Record on Tuesday, October 7, 2003.
- **Oct 8, 2003:** The previous question was ordered without objection.
- **Oct 8, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion of debate on the Schakowsky motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote announced that the noes had prevailed. Ms. Schakowsky demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Oct 7, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 181 - 214 (Roll no. 533). (consideration: CR H9249)
- **Oct 7, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Oct 7, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 161 - 234 (Roll no. 534). (consideration: CR H9250)
- **Oct 7, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Oct 2, 2003:** Mr. Bishop (NY) moved that the House instruct conferees. (consideration: CR H9171-9187; text: CR H9171)
- **Oct 2, 2003:** DEBATE - The House proceeded with one hour of debate on the Bishop (NY) motion to instruct conferees on H.R. 1.
- **Oct 2, 2003:** POSTPONED VOTE - At the conclusion debate on the Bishop (NY) motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote announced that the noes had prevailed. Mr. Bishop (NY) demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Oct 2, 2003:** Mr. Flake moved that the House instruct conferees. (consideration: CR H9180-9187)
- **Oct 2, 2003:** DEBATE - The House proceeded with one hour of debate on the Flake motion to instruct conferees.
- **Oct 2, 2003:** The previous question was ordered without objection.
- **Oct 2, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion debate on the Flake motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote announced that the ayes had prevailed. Mr. Brown (OH) demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Oct 1, 2003:** Mr. Case moved that the House instruct conferees. (consideration: CR H9062-9067; text: CR H9062)
- **Oct 1, 2003:** DEBATE - The House proceeded with one hour of debate on the Case motion to instruct conferees on H.R. 1.
- **Oct 1, 2003:** The previous question was ordered without objection.
- **Oct 1, 2003:** POSTPONED PROCEEDINGS - At conclusion of debate on the Case motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote, announced that the ayes had prevailed. Mr. Case demanded the yeas and nays and the Chair postponed further proceedings on adoption of the motion until later in the legislative day.
- **Oct 1, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 208 - 215 (Roll no. 528). (consideration: CR H9072)
- **Oct 1, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Sep 30, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 202 - 205 (Roll no. 524). (consideration: CR H8989-8990)

Sep 30, 2003: Motion to reconsider laid on the table Agreed to without objection.

- **Sep 25, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 199 - 220 (Roll no. 522).
- **Sep 25, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Sep 25, 2003:** Mr. Sandlin moved that the House instruct conferees. (consideration: CR H8925-8930; text: CR H8925)
- **Sep 25, 2003:** DEBATE - The House proceeded with one hour of debate on the Sandlin motion to instruct conferees.
- **Sep 25, 2003:** The previous question was ordered without objection.
- **Sep 25, 2003:** POSTPONED PROCEEDINGS - At the conclusion of debate on the Sandlin motion to instruct conferees, the Chair put the question on adoption of the motion and by voice vote, announced that the noes had prevailed. Mr. Sandlin demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Sep 24, 2003:** NOTICE OF INTENT TO OFFER MOTION TO INSTRUCT - Mr. Sandlin notified the House of his intent to offer a motion to instruct conferees on H.R. 1.
- **Sep 24, 2003:** Mr. Kind moved that the House instruct conferees. (consideration: CR H8880-8887; text: CR H8880)
- **Sep 24, 2003:** DEBATE - The House proceeded with one hour of debate on the Kind motion to instruct conferees on H.R. 1.
- **Sep 24, 2003:** POSTPONED ROLL CALL VOTE - At the conclusion of debate on the Kind motion to instruct conferees on H.R. 1, the Chair put the question on adoption of the motion and by voice vote, announced that the yeas had prevailed. Mr. Kind demanded the Yeas and Nays and the Chair postponed further proceedings on the question of adoption of the motion until a later time.
- **Sep 23, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 202 - 213 (Roll no. 510). (consideration: CR H8465-8466)
- **Sep 23, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Sep 23, 2003:** NOTICE OF INTENT TO OFFER MOTION TO INSTRUCT - Mr. Kind notified the House of his intent to offer a motion to instruct conferees on H.R. 1.
- **Sep 17, 2003:** Mr. Stenholm moved that the House instruct conferees. (consideration: CR H8361-8366; text: CR H8361)
- **Sep 17, 2003:** DEBATE - The House proceeded with one hour of debate on the Stenholm motion to instruct conferees which was noticed in the Congressional Record on Tuesday, September 16, 2003.
- **Sep 17, 2003:** POSTPONED PROCEEDINGS - At the conclusion of debate on the Stenholm motion to instruct, the Chair put the question on adoption of the motion and by voice vote, announced that the ayes had prevailed. Mr. Stenholm demanded the yeas and nays and pursuant to a previous order of the House, the Chair postponed further proceedings on the question of adoption of the motion until Tuesday, September 23, 2003.
- **Sep 16, 2003:** NOTICE MOTION TO INSTRUCT CONFEREES - Mr. Stenholm notified the House of his intention to offer a motion to instruct conferees on H.R. 1.
- **Sep 10, 2003:** Mr. Michaud moved that the House instruct conferees.
- **Sep 10, 2003:** The House proceeded with one hour of debate on the Michaud motion to instruct conferees which was noticed in the Congressional Record on Tuesday, September 9, 2003.
- **Sep 10, 2003:** POSTPONED PROCEEDINGS - At the conclusion of debate on the Michaud motion to instruct, the Chair put the question on adoption of the motion and by voice vote, announced that the noes had prevailed. Mr. Michaud demanded the yeas and nays and the Chair postponed further proceedings on the question of adoption of the motion until later in the legislative day.
- **Sep 10, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 189 - 220 (Roll no. 502). (consideration: CR 9/11/2003 H8182-8189, H8190-8191; text: CR 9/11/2003 H8182)
- **Sep 10, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Sep 9, 2003:** NOTICE OF MOTION TO INSTRUCT CONFEREES - Mr. Michaud of Maine notified the House of his intention to offer a motion to instruct conferees on H.R. 1.
- **Jul 14, 2003:** Mr. Tauzin asked unanimous consent that the House disagree to the Senate amendments, and agree to a conference.
- **Jul 14, 2003:** On motion that the House disagree to the Senate amendments, and agree to a conference Agreed to without objection. (consideration: CR H6658-6666, H6680-6681)
- **Jul 14, 2003:** Mr. Davis (TN) moved that the House instruct conferees.
- **Jul 14, 2003:** The motion instructs conferees to (1) reject the provisions of subtitle C of title II of the House bill and; (2) that the House recede to the Senate on the provisions to guarantee access to prescription drug coverage under section1860D-13(e) of the Social Security Act, as added by section 101(a) of the Senate amendment.
- **Jul 14, 2003:** DEBATE - The House proceeded with one hour of debate on the Davis (TN) motion to instruct conferees.

Jul 14, 2003: The previous question was ordered without objection.

- **Jul 14, 2003:** POSTPONED PROCEEDINGS - At the conclusion of debate on the Davis (FL) motion to instruct conferees the Chair put the question on the motion and by voice vote, announced that the noes had prevailed. Mr. Davis (FL) demanded a recorded vote and the Chair postponed further proceedings on the question of adoption of the amendment until later in the legislative day.
- **Jul 14, 2003:** On motion that the House instruct conferees Failed by the Yeas and Nays: 191 - 221 (Roll no. 359).
- **Jul 14, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Jul 14, 2003:** The Speaker appointed conferees for consideration of the House bill and the Senate amendments, and modifications committed to conference: Tauzin, Thomas, Bilirakis, Johnson (CT), DeLay, Dingell, Rangel, and Berry.
- **Jul 8, 2003:** Message on Senate action sent to the House.
- **Jul 7, 2003:** Received in the Senate.
- **Jul 7, 2003:** Measure laid before Senate by unanimous consent. (consideration: CR S8898-8997)
- **Jul 7, 2003:** Senate struck all after the Enacting Clause and substituted the language of S.1 amended.
- **Jul 7, 2003:** Passed/agreed to in Senate: Passed Senate in lieu of S.1 with an amendment and an amendment to the Title by Unanimous Consent.(text: CR S8898-8997)
- **Jul 7, 2003:** Passed Senate in lieu of S.1 with an amendment and an amendment to the Title by Unanimous Consent. (text: CR S8898-8997)
- **Jul 7, 2003:** Senate insists on its amendments, asks for a conference, appoints conferees Grassley; Hatch; Nickles; Frist; Kyl; Baucus; Rockefeller; Daschle; Breaux.
- **Jul 7, 2003:** See also S.1.
- **Jun 27, 2003:** DEBATE - The House continued with the balance of the debate on H.R. 1.
- **Jun 27, 2003:** Mr. Thompson (CA) moved to recommit with instructions to Ways and Means. (consideration: CR 6/26/2003 H6181-6255)
- **Jun 27, 2003:** DEBATE - The House proceeded with 10 minutes of debate on the Thompson (CA) motion to recommit with instructions. The instructions contained in the motion seek to require the bill to be reported back to the House with an amendment in the nature of a substitute which adds a complete new text.
- **Jun 27, 2003:** The previous question on the motion to recommit with instructions was ordered without objection.
- **Jun 27, 2003:** On motion to recommit with instructions Failed by recorded vote: 208 - 223 (Roll no. 331). (text: CR 6/26/2003 H6181-6254)
- **Jun 27, 2003:** Passed/agreed to in House: On passage Passed by recorded vote: 216 - 215, 1 Present (Roll no. 332).
- **Jun 27, 2003:** On passage Passed by recorded vote: 216 - 215, 1 Present (Roll no. 332).
- **Jun 27, 2003:** Motion to reconsider laid on the table Agreed to without objection.
- **Jun 26, 2003:** Rules Committee Resolution H. Res. 299 Reported to House. Rule provides for consideration of H.R. 1 and H.R. 2596 with 3 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Measure will be considered read. A specified amendment is in order. Amendment in the nature of a substitute by, and if offered by, Mr. Rangel is debatable for one hour. H.R. 2596 shall be considered in the House and after final adoption, shall be appended to the text of H.R. 1. H.R. 2596 will then be laid on the table. Concurrent resolutions providing for adjournment of the House and Senate in July shall be in order for consideration. Finally, the Committee on Appropriations shall have until midnight on Thursday, July 3, 2003 to file a report making appropriations for
- **Jun 26, 2003:** Considered under the provisions of rule H. Res. 299. (consideration: CR H6007-6105, H6107-6256; text of measure as introduced: CR H6007-6077)
- **Jun 26, 2003:** Rule provides for consideration of H.R. 1 and H.R. 2596 with 3 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Measure will be considered read. A specified amendment is in order. Amendment in the nature of a substitute by, and if offered by, Mr. Rangel is debatable for one hour. H.R. 2596 shall be considered in the House and after final adoption, shall be appended to the text of H.R. 1. H.R. 2596 will then be laid on the table. Concurrent resolutions providing for adjournment of the House and Senate in July shall be in order for consideration. Finally, the Committee on Appropriations shall have until midnight on Thursday, July 3, 2003 to file a report making appropriations for
- **Jun 26, 2003:** DEBATE - Pursuant to the provisions of H. Res. 299, the House proceeded with 3 hours of general debate on H.R. 1.
- **Jun 26, 2003:** DEBATE - Pursuant to the provisions of H. Res. 299, the House proceeded with one hour of debate on the Rangel amendment in the nature of a substitute.

Jun 25, 2003: Introduced in House

- **Jun 25, 2003:** Introduced in House
- **Jun 25, 2003:** Referred to the Subcommittee on Health.
- **Jun 25, 2003:** Referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
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