Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lynch
Mack
Maloney (NY)
Markey
Marshall
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCollum (MN)
McCotter
McDermott
McGovern
McIntyre
McNerney
Meek (FL)
Meeks (NY)
Melancon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Mitchell
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murphy, Tim
Murtha
Nadler
Napolitano
Neal (MA)
Neugebauer
Obey
Olver
Ortiz
Pallone
Pastor
Paul
Payne
Pearce
Perlmutter
Peterson (MN)
Pitts
Platts
Poe
Pomeroy
Porter
Price (GA)
Price (NC)
Putnam
Ramstad
Rangel
Regula
Richardson
Rodriguez
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Rothman
Roybal-Allard
Royce
Ruppersberger
Ryan (OH)
Salazar
Sali
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Scalise
Schakowsky
Schiff
Schmidt
Schwartz
Scott (GA)
Serrano
Sestak
Shays
Sherman
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Space
Stark
Stearns
Stupak
Sutton
Tanner
Tauscher
Taylor
Terry
Thompson (CA)
Thornberry
Tiahrt
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Towns
Tsongas
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walberg
Walden (OR)
Walsh (NY)
Walz (MN)
Wasserman Schultz
Waters
Watson
Watt
Waxman
Welch (VT)
Weldon (FL)
Weller
Westmoreland
Wilson (NM)
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Wittman (VA)
Wolf
Wu
Young (FL)

NOT VOTING—50

Boswell
Boucher
Cannon
Cardoza
Costa
Courtney
Davis (IL)
Davis, Lincoln
Delahunt
DeLauro
Engel
Eshoo
Gillibrand
Gohmert
Jefferson
Johnson (IL)
Larsen (WA)
Mahoney (FL)
McNulty
Miller, George
Mollohan
Nunes
Oberstar
Pascrell
Pence
Peterson (PA)
Pryce (OH)
Radanovich
Rahall
Reyes
Reynolds
Ross
Rush
Saxton
Scott (VA)
Shea-Porter
Souder
Speier
Spratt
Tancredo
Thompson (MS)
Tierney
Turner
Udall (CO)
Wamp
Weiner
Wexler
Wilson (SC)
Woolsey
Yarmuth

□ 1116

Messrs. SESTAK and KUCINICH changed their vote from ''yea'' to ''nay.''

So the motion to adjourn was rejected.

The result of the vote was announced as above recorded.

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008—Continued

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Texas (Mr. BARTON) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that the gentleman from New York (Mr. RANGEL) be permitted to control 10 minutes of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

I rise in strong support of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008, and I urge my colleagues on both sides of the aisle to offer their support for this bill.

H.R. 6331 would make a number of improvements that are important to protecting the health and well-being of our seniors. The legislation also addresses the reimbursement concerns of doctors who treat Medicare patients. It also completely is paid for by implementing sensible reforms to the Medicare Advantage program that is supported by almost every expert body, including MedPAC and GAO.

Mr. Speaker, while I still believe that the CHAMP Act, which the House passed last year, was the best way to address Medicare's future, the bill before us today is a reasonable compromise that both Democrats and Republicans should support. In the end this legislation would allow us to take the steps necessary to keep Medicare working for America's seniors, doctors, and taxpayers. And with less than a week to go before the impending physician cuts go into effect, it is time to put politics aside and pass this commonsense policy.

Mr. Speaker, I reserve the balance of my time, and I ask unanimous consent that the gentleman from Georgia (Mr. BARROW) be permitted to control the balance of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I would ask unanimous consent that the gentleman from Michigan (Mr. CAMP) be allowed to control 10 minutes for debate purposes of the time that I control.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, I rise today in opposition to H.R. 6331, the Medicare bill that is put before this Congress today on a suspension vote.

Somehow I missed it, but I didn't see the notice of the legislative hearing in the Energy and Commerce Committee hearing on this. I didn't see the notice of the subcommittee markup on this bill. I didn't see the full committee notice to have a markup. I didn't get any notice of the technical corrections of the bill, which we received at 10 minutes until 10 a.m. this morning.

The majority seems to be under the mistaken impression that the less input and the less Republicans know about major bills, the more likely we are to vote for them. Well, I have a news flash. When we were not a part of the process, when we don't have any input into the policy, there is over a 95 to 100 percent we are going to be ''noes'' regardless of the substance of the bill.

On this particular bill, had we had some input, we would have strongly opposed the cuts to Medicare Advantage. A large number of us would have opposed the delay in the durable medical equipment competitive bidding that's supposed to go into effect on July 1 and, under the current bill, is also delayed for 18 months. There is obviously a need to fix the current physician reimbursement system. We have been in session now in this Congress almost 18 months, perhaps longer. You would think that in that time period, there could have been some legislative hearings. There could have been some draft proposals floated. There could have been some markups and some discussion and some give and take, and we could have found a compromise that would pass on the suspension calendar. But that has not been the case, as it was not the case on the CHAMP Act that my good friend from New Jersey just referred to.

So, Mr. Speaker, on this particular piece of legislation for this morning, I would strongly urge a ''no'' vote and ask all Members of this body that believe in regular process and give and take in policy reform to vote ''no,'' and then sometime when we come back after the July 4th work period, perhaps we can work together to do what needs to be done.

Mr. Speaker, I rise today to oppose H.R. 6331, the Medicare bill put before this Congress today on a suspension vote. While I a agree that we should do something to address the Medicare physician payment cut that will take affect in just a few days, I do not support cutting Medicare Advantage to pay for this short-term fix.

This legislation cuts close to $50 billion from Medicare Advantage, a program that benefits seniors in every State and a program in which our seniors are deeply satisfied. I believe people benefit when they have the kind of choices that only market competition can provide, and that certainly includes choice in health care. As we have seen with the Medicare Part D drug benefit, when an entitlement program is subjected to market forces, everyone is a winner. The taxpayer gets lower spending in an entitlement program; the beneficiary pays lower premiums and co-pays; and we get to provide broader access to affordable and accountable health care for our seniors.

Yes, it is true that this bill provides temporary relief for payment cuts for physician services for the next year or so. So I guess as

Members we can rest assured that this problem will disappear for the next 18 months.

But what else have we signed on to if we are to pass this bill today? We have signed on to massive entitlement expansion through the revisions to the low-income subsidy and Medicare savings program. We have signed on to eliminating private, fee-for-service Medicare Advantage plan options that are currently available in 48 States. We have signed on to significant cuts in payment to all Medicare Advantage plans that work with teaching hospitals across this country. And last but not least, we have signed on to a process by which our own committees are now rendered useless in this Congressional body.

Over the course of the past year, there has not been one single Medicare hearing in the Energy and Commerce Committee. Not one. I guess the doc fix is so important that it justifies taking a significant, political, and complex bill straight to the floor under a vote by suspension of the rules.

That means no consideration by the committees of jurisdiction and no amendments on the floor. For an issue that the Democrats like to consider bipartisan—avoiding a physician payment crisis—one has to ask, why not work with Republicans to enact something earlier and more meaningful?

We know why we are here today. If the Speaker is able to jam this down our throats today, we know that it will hit a brick wall in the Senate. How do we know this? Because this bill is just about like the one that recently failed in the Senate. And, the President has indicated that he will veto it, in the unlikely event that it passes both bodies.

So, we see that today's vote for a physician payment fix is merely the political exercise Republicans must endure so that Democrats may turn to their constituents when they return for the holiday next week and say, "See, I tried to help you but those abominable old Republicans, why they just wouldn't let me. They don't even like puppies, I heard."

This bill temporarily stops the hemorrhaging, but it does not fix the long-term problem of physician payment. And the cure is likely worse than the illness—the doc fix is at the expense of our senior who enjoy their MA benefit.

I oppose this bill. I oppose the process—no committee hearings; no committee markups; no mention of the word Medicare in our committee at all.

Last year, I decried the politics of some of debates we had, and I was told that politics is a good thing for this body. Well, we're all elected to these seats, so we know a thing or two about politics, but at some point the people who elected us expect us to quit politicking and start governing. Too often this new Democratic Majority lacks the ideas they need to govern, and so they revert to politics.

Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I yield myself 3 minutes, and I ask unanimous consent that the remainder of my time go to the distinguished chairman of the Health Subcommittee of the Committee on Ways and Means.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. RANGEL. Mr. Speaker, I wish we weren't legislating this way, as the gentleman has pointed out, on the suspension calendar, but as you know, it's difficult working with the other House. They have our CHAMP bill over there, and there is no telling what we might do if we don't come right now and deal with this emergency before these provisions expire.

This would allow the Secretary to add preventative benefits without waiting for the Congress. It would help us out in Medicare. And we have been able to gather the support of the doctors, the hospitals, the pharmacists, those that are concerned with durable medical expenses, the dialysis people, wheelchair. And so we made an attempt, even though it is patchwork and it's not a piece of legislation we're proud of. But if we don't move in this House, the effects of not doing anything would be more detrimental than trying to get a perfect bill.

We have been working desperately hard to try to get something that all of the people could agree to, but, unfortunately, we haven't had an opportunity to do that. And we also are concerned with the teaching hospitals with suggestions that we have heard that they would pay for the whole thing when we know that a physician's fee for service is an area that should equally bear the costs of trying to get this legislation through.

So I really don't think we have much of a choice. Our votes are being recorded. People are watching what we do. And I do hope that we can do a better job next year. But the whole idea is to make certain that the House is responsible, and while we don't have any indication of what's going to happen in the other body, it seems to me that we should move on this bill.

I want to thank Congressman STARK for the great work he and his staff have done. It's always a moving target as to what we can get in, what we can't get in. But I don't think there is anyplace we can go for now except to support the suspension, and then whatever corrections we have to do, we should do it next year.

Mr. Speaker, I reserve the balance of my time.

Mr. CAMP of Michigan. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, Medicare bills should be bipartisan and should be fully debated, not on some shortened suspension calendar. My question is just what about this bill worries the majority that they won't fully debate it?

Today we are discussing a serious issue, how to prevent Medicare from cutting physicians' payments by over 10 percent by next Tuesday. Make no mistake. That will happen if Congress does not act, and despite virtually every Member of this House being opposed to such a cut to doctors, here we are only a week away from that happening.

And, sadly, this shouldn't surprise any of us. Shortly after Congress passed the last short-term extension in December, the chairman of the Ways and Means Health Subcommittee noted that he was inclined to do nothing to stop the cut from taking place. And that's exactly what this majority has done for the past 6 months: nothing.

In the last couple of days, this bill has been drafted in secret, and a recent version just appeared at 10 o'clock this morning, 278 new pages of bill. But this bill has been drafted in secret without committee hearings, without committee markups, without committee amendments, and without any chance for public review.

This is the most restrictive Congress in our Nation's history. Neither the minority or majority should find this way of doing the people's business acceptable. It is certainly not what the Speaker promised us or promised the American people.

Maybe that's why when you break the public's trust in this way, your approval numbers plummet. This is the most unpopular Congress ever, and that's saying a lot. The American people want an open, accessible, and accountable government, and they are not getting it from this majority.

So today here we are rushing to pass a bill that couldn't muster enough support in the Senate to even be debated and one that is sure to be vetoed by the President, if it ever got that far. It's the first time I have ever seen this House in such a rush to take up the scraps of the Senate, and, frankly, we would be equally wise to reject this so-called fix. I know I speak for all of my colleagues on this side of the aisle when I say we want to prevent this cut and, in fact, we want to provide physicians with a payment increase. Yet with this bill, we are cutting seniors' access to affordable health care under Medicare some $47 billion, causing 2 million seniors to lose access to health care through Medicare Advantage. What we give some providers we directly take away from beneficiaries. This is no way to manage Medicare.

It is my sincere hope that we can ultimately pass a bipartisan compromise this week. A compromise is imminent in the Senate as we speak. Physicians deserve no less, and certainly beneficiaries, America's seniors, and the disabled deserve no less.

I urge my colleagues to vote "no" and to demand a Medicare doctor fix that is workable for all parties involved.

Mr. Speaker, I reserve the balance of my time.

Mr. BARROW. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, without H.R. 6331 many doctors across the country will not be able to afford to see and treat Medicare patients. In a rural district like mine where a greater percentage of the population depends on Medicare for their health care, that's not acceptable. We are lucky to have world-class health care in this country, but health care is only as good as an individual's ability to get to that health care and their

ability to afford it. H.R. 6331 will keep our doctors in business so that our Nation's poor and elderly can get the health care that they need.

I am proud of the fact that H.R. 6331 contains some specific relief for folks in rural areas, making sure that rural doctors get paid fairly, increasing payments to critical access hospitals, and covering the additional fuel costs faced by ambulances in rural districts. This bill will also help poor seniors by increasing the amount of assets that a low-income beneficiary can have and still qualify for financial help with Medicare costs.

I recently spent a week touring just about every kind of health care facility in my district. Folks back home have a lot of problems with our health care system. While this bill doesn't fix everything that's broke with Medicare, it is a big step forward and we absolutely need it.

Mr. Speaker, we have until July 1 to stop these cuts from taking effect.

□ 1130

Unless we adopt this legislation before then, doctors all across the country will have to start turning away Medicare patients that they are seeing right now. We can't let that happen. I therefore urge my colleagues to support this bill.

I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I want to yield 2 minutes to a member of the Energy and Commerce Committee, the gentlewoman from Tennessee (Mrs. BLACKBURN).

Mrs. BLACKBURN. I thank the gentleman from Texas.

Mr. Speaker, he mentioned earlier in his comments the lack of hearings that we have had on this issue. Indeed, this morning over in Energy and Commerce there is a hearing on health issues, but nothing to do with Medicare reform, nothing to do with this situation that is before us right now. Indeed, late notice was mentioned.

Mr. Speaker, I think that what we see here is a pattern that is developing with the majority party, and when they don't want to talk about something, they don't want to debate it on the floor, they want to maybe cover a few things into the bill, then we have it on suspension calendar. I find that very unfortunate.

I will say this. With H.R. 6331, 89 percent of our seniors in Tennessee that are enrolled in Medicare Advantage would be adversely impacted by this bill. This is something, this bill, H.R. 6331, would leave a lot of our elderly patients and doctors in peril, while the leadership in this body is playing politics with Medicare.

We have heard about the 10 percent cut on July 1. We have heard about procrastinating and leaving this until the 11th hour rather than taking significant action. Mr. Speaker, I think that we have to look at what is happening to Medicare. I am deeply concerned about this issue and how it impacts our seniors.

We know that the Medicare trust fund is likely to go bankrupt in 2019. These aren't my figures, these are the Congressional Budget Office figures. We know that this year, we hit the 45 percent trigger, which occurs when Congress is obliged to find a new way to curb Medicare spending. This bill does not do one thing to curb that spending. It makes it worse. It is unfair to our seniors.

I urge a ''no'' vote.

Mr. STARK. Mr. Speaker, I yield myself 2 minutes.

(Mr. STARK asked and was given permission to revise and extend his remarks.)

Mr. STARK. Mr. Speaker, I urge my colleagues to support H.R. 6331. For whatever reasons, people may be concerned with process. To me, that is a snare and a delusion. Basically, this bill protects the physicians from their 10 percent cuts. If you vote against it, you're voting to cut physicians by 10 percent.

It improves benefits for seniors and people with disability, it ends discriminatory mental health copayments. So vote against the bill and seniors don't get mental health treatment. It targets extra help to low-income people. Vote against the bill and you're, as Republicans like to do, trashing low-income people for the benefit of rich insurance companies, the only one group that opposes this bill.

It delays the durable medical equipment competitive bidding demonstration, which we have agreed on a bipartisan basis should be delayed. Vote against the bill and let the medical equipment competitive bidding go ahead. It makes improvements in quick pay for pharmacists. Vote against the bill and talk to your local pharmacists, my Republican friends, and see what they think about your voting against the bill, which would otherwise provide them prompt payment.

The clinical labs, therapy services, rural providers, psychologists, social workers, dialysis patients all get help in this bill. So vote against it and go back and talk to your constituents who depend on those services for their quality of life.

I am ready to have you do that because all of this is paid for in a balanced, fair method, suggested, I might add, by the administration's own actuary, and the Government Accountability Office and MedPAC all say that trimming the payments to Medicare Advantage is the right thing to do, and will extend the life of the Medicare trust fund.

So it's not a bill I wish we were considering. The CHAMP Act, which many of you voted, is one. But this is a modest compromise. I urge its support.

For several years now, I have pushed to modernize Medicare's reimbursement for ESRD, consistent with longstanding recommendations from the Medicare Payment Advisory Commission, MedPAC, and the Government Accountability Office, GAO. The current payment system includes a perverse financial incentive to dose higher levels of the anti-anemia drug, Epogen, which can put patients at risk of death and serious cardiovascular events. Both MedPAC and GAO recommend replacing this system by reimbursing providers with one ''bundled'' payment for dialysis services and related drugs and labs, thereby removing the incentive to overuse items and services that are currently separately billed. This will encourage more efficient provider behavior while maintaining and improving patient care. This modernized payment system is consistent with the philosophy governing many of Medicare's other payment systems.

It is imperative bundling be done in a way that is sensitive to individual patient needs, protects against provider stinting, and is not ''one-size-fits all.'' Including an outlier pool, risk adjustment, and a strong quality performance system all work to ensure that appropriate care is ensured.

That is why I was very proud when the Children's Health and Medicare Protection, CHAMP, Act, which passed the House in August 2007, advanced ESRD bundling with these patient protections. That is also why I am disheartened by the ESRD bundling proposal before us today, as I have several serious concerns with this package.

First, I am very disappointed to see that much of this package is designed to appease the profit-hungry interests of the dialysis and pharmaceutical companies. I have long believed that dialysis providers should meet strong quality standards in order to receive increased payments. I oppose the automatic updates in this bill. I hope that when structuring the quality incentive program, CMS pushes dialysis providers to meet a rigorous set of standards in order to get payment increases. In CHAMP, providers had to meet a clear and strong set of quality measures in order to receive bonus payment.

Unfortunately, the initial anemia management quality measure in this bill is seriously flawed. The MIPPA quality measure tells providers that they are providing acceptable care as long as they haven't gotten worse than their past track record. That's like telling a D-student that they are doing fine as long as they keep getting at least D grades.

This is wrong. We should be encouraging providers to improve the care provided. There are serious health issues at stake, with the FDA warning that using anti-anemia drugs in a way that raises red blood cell levels too high puts ESRD patients at risk of death or cardiovascular events. Sadly, the measure in MIPPA gives providers a pass as long as the care provided just doesn't get worse.

Instead, we should be encouraging providers to get more patients within FDA's recommended range for anemia management. We tried to do this in CHAMP when we designed something that pushed providers to at least meet the national average, with the bar getting raised in subsequent years. If the MIPPA quality measure is enacted into law, I intend to work to override or modify it. I hope that the Centers for Medicare and Medicaid Services will instead develop a system that pushes providers toward improved performance and assesses them against anemia management measures that are consistent with the FDA label.

A second flaw in this package is that it allows the large dialysis organizations, LDOs, to

benefit from a mandated low-volume adjustment. I have no problem with a low-volume adjustment if it is warranted and set right. However, LDOs don't need it, and they shouldn't get it. Repeated studies by the HHS Office of Inspector General show that LDOs are able to get much better prices on dialysis-related drugs than smaller dialysis organizations. Even if an LDO has a low-volume facility, that facility still benefits from the price discounts negotiated with the parent corporation. Giving LDOs a low-volume adjustment is an unnecessary waste of money.

Another flaw with the MIPPA package is that it only lets facilities fully opt-in to the bundled payment system in the first year of the phase-in. I suspect that facilities will find the incentives for practice patterns under the old system and new systems to be in conflict, and may quickly realize that moving directly to bundling in year two is easier. To the extent bundling incentivizes more efficient behavior and has the necessary patient protections, if a facility wants to opt-in in year two or three, I see no reason to stop them.

I would also like to clarify something about the bundle itself. MedPAC has repeatedly pushed for a broader ESRD bundle. My understanding of the MIPPA language is that it provides for inclusion of all oral dialysis-related drugs in the bundle, including calcimimetics and phosphate binders. Specifically the term "items and services" at clause (14)(B)(iv) of the Social Security Act, as amended by MIPPA, and the reference to "other drugs and biologicals" at clause (14)(B)(iii), both afford the Secretary broad discretion to include oral drugs furnished to an individual for the treatment of end stage renal disease that don't necessarily have an IV equivalent.

I know why some pharmaceutical companies want to exclude these drugs from the bundle. They want another product line where they can play their separately billable game and try to drive up utilization and corporate profits. That is contrary to the philosophy of bundling and not the intent of Congress.

These drugs should be included in the bundle to prevent cost shifting to Part D in order to circumvent the new bundled payment. Most importantly, it would ensure that decisions as to which drug a patient receives are driven by clinical decisions not reimbursement policy. This will also ensure that all drugs furnished to patients for the treatment of ESRD are captured in the new bundled payment.

I also believe the bundle should set in a way, including any appropriate adjustments, so that more frequent home dialysis, both peritoneal and hemodialysis, is adequately paid and encouraged.

ESRD bundling is long overdue, but it is unfortunate that industry has demanded such a high price for it. If this bill becomes law, I intend to keep pushing for these changes and will be watching and weighing-in heavily as CMS moves forward with implementation.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to address their remarks to the Chair.

Mr. CAMP of Michigan. I yield 1 minute to a respected physician, the gentleman from Louisiana (Mr. BOUSTANY).

Mr. BOUSTANY. I thank my colleague for yielding time to me.

As a physician, I am deeply disappointed in the way we are legislating on health care. Here we are, on one hand, physicians are facing a 10 percent cut in reimbursement, which is going to deeply have an impact on access. Furthermore, a 5 percent cut coming up in January. On the other hand, we are going to cut $47 billion out of a Medicare program that is extremely valuable to rural America.

I have a substantial number of citizens, constituents in my district, who depend on this program for access, not just coverage. Coverage is something on paper. Coverage gets you, hopefully, into the door, but not necessarily into the door of a physician's office where they can have a physician-patient relationship, a meaningful relationship that focuses on prevention and screening and not just treating everybody as if they are just a cog or an animal.

We want to do good health care, and this is an irresponsible way to do this. This bill does not pay attention to access; it simply glosses over it. It pits seniors, seniors against physicians. As a physician, I deeply resent that.

Mr. BARROW. Mr. Speaker, I am pleased to yield 1½ minutes to the distinguished chairman of the Committee on Energy and Commerce, the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I thank my good friend from Georgia, and I congratulate him on the way he is handling this legislation. We are proud of him and his service.

Mr. Speaker, the legislation before us today is critical to ensuring high quality physician services for Medicare beneficiaries. If you want to cabal about that, you're making a great mistake. If this legislation fails, physicians are going to face a 10 percent pay cut, and that is going to drive them out of Medicare and it's going to threaten the security and the health care of senior citizens and the disabled.

At the same time, this legislation provides additional protections for low-income beneficiaries, adds benefits to the traditional Medicare program, such as coverage for more preventive benefits. It will also address the Medicare drug benefit and make it work better for pharmacists and therefore seniors.

Finally, the legislation addresses one of the most egregious problems, and that is private plans operating in Medicare. Private Fee-for-Service plans, or PFFS plans, which is one type of Medicare Advantage plan. There, they are cutting a fat hog at the expense of the public. If you do away with that particular vice, you will find you are making it more solvent over a long period of time and you are using a mechanism which will help our senior citizens to know that their Medicare is protected and seeing to it that the doctors are there to provide the care that is needed. We are also assuring that the pharmacists are able to stay in this business by addressing a significant hurt that they are undergoing.

I urge my colleagues to support this legislation and not to cabal about the perfection of the process.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 30 seconds.

I think we are entitled to cabal about the process. We represent about 48 percent of the American people and have had absolutely no input into a multi, multibillion-dollar temporary fix. This would only go into effect for 1 year. It doesn't solve the long-term program. So I think we are entitled to a little caballing, as they said.

I want to yield 2 minutes to the distinguished gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. I thank the gentleman from Texas.

Florida 5 is the district that I represent, and it is not a wealthy area. I have the highest number of people on Social Security of any Member of this Congress, and obviously a huge number on Medicare.

Medicare Advantage is a very popular program. And why is it popular? It's popular because many of the programs, and by the way, there's a large variety of programs for the seniors to choose from, many of the programs will actually pay the seniors' part B cost.

When you represent a district that isn't wealthy, let me assure the Members of both sides of the aisle that this is an important medical program and it does give them choices. Nobody is forced into the Medicare Advantage plans, but they join them because it saves them money, while offering quality health care.

Yes, we all want to fix the cuts to the doctors. Yes, we want to make sure that the DME program is revised, and revised well. But we all know that it has already been said the Senate won't accept it, the President has just issued a veto threat on it, and so my question is: Why are we here?

Obviously, July 1 is right around the corner, and to take this up at the last minute when the bill was only available at 10 o'clock this morning, I think is an insult. It's an insult to the people who like the Medicare Advantage program and it certainly is an insult to every Member of this Chamber, 278 pages of a bill that we really don't know everything that is in it because it's now a little after 11:30 in the morning. So obviously nobody has had the time to adequately review the bill.

Medicare Advantage is a good program that helps so many low-income seniors. People have to ask: Why does the Democrat Party want to do away with this program? Shame, shame, shame.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, I want to thank my friend, the chairman of the Subcommittee on Health, for yielding.

Mr. Speaker, like any other great and necessary journey, the journey to improve Medicare must start with a first step. Although we can and must do more, this bill is that first step.

I want to just mention the pulmonary rehabilitation benefit and the

kidney provision, which I strongly support, and the increase in the community health center cap. Seniors deserve a Medicare program that delivers services, supports doctors, and prevents disease.

Take this first step. It is a good step, it is a necessary step. It is the right thing to do. I urge all of my colleagues to support this bill.

Mr. CAMP of Michigan. I yield 2 minutes to a physician and respected Member of this House, the gentleman from Georgia (Mr. PRICE).

Mr. PRICE of Georgia. I thank the gentleman.

As a physician, nothing is more important to me than patients and the ability of doctors to take care of them. One of the reasons that I ran for public office was to work as diligently as I could to get politics out of the clinical exam room and out of the operating room.

The process that has brought this bill to the floor, a new bill of over 270 pages, just this morning, reveals the cynical and solely political activity of the majority leadership, a crisis of leadership in this House. No hearing, no amendments, no fairness, no recognition of the true needs of patients and doctors.

Politics over policy, politics over people. Shame, Mr. Speaker. Shame.

MR. BARROW. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, the Medicare Improvements for Patients and Providers Act not only eliminates the scheduled 20 percent cut to physicians, which is set to take place next week, but it also will provide numerous other protections. It provides incentives for prescriptions for e-prescribing technology and it extends and vastly improves low-income assistance programs for very low-income Medicare beneficiaries.

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And this bill includes a very important 2-year reauthorization of the special diabetes programs for type 1 diabetics and American Indians. Thanks to over a decade of investment in these programs, we can point to tangible and significant progress, like the creation of an artificial pancreas. It is vital for a multiyear reauthorization because of the structure of the NIH funding cycle, and I want to thank my chairman and the leadership for including this language in the bill. There are other wonderful protections in the bill for diabetics and for other Medicare beneficiaries.

I just want to close by saying one thing: The language in this bill and the concepts are not new today. We have been talking them to death for 2 years. This program expires next week, and I don't think that the patients of America and the doctors of America are going to be too sympathetic about process arguments, when what they really care about is being able to provide quality medical services to low income and to senior citizens in this country.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, again, I have missed the legislative hearing on this issue in the last 18 months. Maybe they had it in the other body, but we haven't had it here. The actual bill that we are addressing, we got it at 10 minutes until 10 this morning. This is the same group that passed a farm bill that left out a complete title, and we are passing a 278 page bill that the original substance I think we got Friday or Monday, the technical corrected copy we got at 10 until 10.

I may be mistaken, but I believe if we had a process that worked and had enough time to think about it, if we had actually been holding hearings and substantive markups and all that is on the books of how the Congress is supposed to work, we would probably have a bill for the suspension calendar that both parties could work for. But the way our friends in the majority are operating these days, the proof is in the pudding.

I would strongly recommend a ''no'' vote, and then let's do it right. Let's do it right so we can vote for it.

Mr. STARK. Mr. Speaker, I would like to yield to the gentlewoman from Kansas (Mrs. BOYDA) for a unanimous consent request.

(Mrs. BOYDA of Kansas asked and was given permission to revise and extend her remarks.)

Mrs. BOYDA of Kansas. Mr. Speaker, I rise in support of H.R. 6331, along with the National Community Pharmacists Association, the Kansas Pharmacists, the National Rural Health Care Association, the American Medical Association, the Kansas Medical Society, the American Hospital Association, the Kansas Hospital Association, the Federation of American Hospitals, and on and on.

These people agree that passage of this bill is vital for Medicare and America's seniors, and certainly for people with disabilities.

Mr. STARK. Mr. Speaker, I yield to the gentleman from Rhode Island (Mr. KENNEDY) for the purpose of making a unanimous consent request.

(Mr. KENNEDY asked and was given permission to revise and extend his remarks.)

Mr. KENNEDY. Mr. Speaker, I rise in support of H.R. 6331, to extend my support along with Mental Health America for equal coverage for our seniors for mental health. This bill supports mental health parity, and that is why we should pass this bill.

Mr. STARK. I yield to the gentleman from Washington (Mr. MCDERMOTT) for the purpose of making a unanimous consent request.

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. I rise in support of H.R. 6331, along with the American College of Cardiology, the American College of Physicians, the American College of Radiology and the American College of Surgeons. All the medical organizations are supportive of this bill.

Mr. STARK. Mr. Speaker, I am happy to yield 1 minute to the distinguished gentleman from California (Mr. BECERRA).

Mr. BECERRA. I thank the gentleman for yielding.

Mr. Speaker, 2 years of debate, a 10 percent cut, 40 million American seniors at risk, and 6 days before the clock strikes 12. That is where we are. Regardless of what anyone says, that is where we are. We need to do something. The time to act is now.

The bill before us is actually a Senate version of an attempt to come up with a modest bipartisan fix. Is it the best bill we could have? Absolutely not. But it is a fix that avoids a 10 percent cut, which could cause many physicians across the country to say no mas. I cannot afford to do this. And it would cause 40 million American seniors to say where do I get my health care?

We need to do something. That is why the Alliance for Retired Americans, the American Association for Health Care, the American College of Physicians, the American College of Surgeons, the American Medical Association, the Federation of American Hospitals, the National Committee to Preserve Social Security and Medicare, the National Community Pharmacists Association, and the National Rural Health Association have said please stop the partisanship. Pass this bill.

Mr. CAMP of Michigan. Mr. Speaker, I yield 2 minutes to the distinguished ranking member of the Committee on Ways and Means, the gentleman from Louisiana (Mr. MCCRERY).

(Mr. MCCRERY asked and was given permission to revise and extend his remarks.)

Mr. MCCRERY. Mr. Speaker, I rise in opposition to the bill on the floor today. I have some prepared remarks that I am going to submit for the RECORD, but rather than reiterate the problems that we have with the process that brought this bill to the floor, let me say my good friend Mr. STARK has been talking with us all along about this problem. We have all been aware of it. And, frankly, it was our understanding in talking with the distinguished chairman of the Health Subcommittee of the Ways and Means Committee that we were going to try to let the Senate, our colleagues in the Senate, work out a bipartisan solution to this take that we could then embrace and bring to the floor.

They were not able to do that at first in the Senate, so we frankly were kind of scrambling to figure out what we were going to do. But now we are told that our friends in the Senate have indeed reached a bipartisan compromise on this issue. They hope to bring it to the floor within the next day or two.

At that time, we could take that bill on a bipartisan basis in the House and embrace it and pass it and get this problem behind us. So why are we doing this today? I am not really sure. It baffles me.

This is a bill that does not have bipartisan support. It did not get 60 votes in the Senate. It couldn't even come up on the floor for a vote. The President would veto it. It is clear this bill is not going to become law.

So I think we are wasting our time here today, to be frank. We ought to be joining arms and hoping that the Senate gets that bill to us, the new compromise bipartisan bill, in a timely fashion so we can get it done this week and avert the drastic cut to reimbursements for physicians, as well as the other things that will occur with caps on services to seniors and the like.

So, Mr. Speaker, I would urge us to defeat this bill today on a bipartisan basis, and then get about the serious business of passing a bipartisan bill later this week that can become law.

I rise in opposition to H.R. 6331.

The Majority notified us at 10 o'clock this morning that they have made a number of changes to the bill that they told us would be on the floor. Members have had just one hour to review this 278-page bill, which moves tens of billions of dollars around in the Medicare program. The limited time for review of such an important measure should give every Member pause.

For six months now, the Democratic Majority in the House has known that physicians face a looming 10.6 percent cut to their Medicare payments.

Now with just six days left before this cut is scheduled to take effect, they are bringing a bill to the floor that we all know will never be signed into law. The Senate considered a similar bill 2 weeks ago and they could not even get the 60 votes necessary to be able to debate the bill. We also know that the President would veto this bill, because of the changes it makes to the Medicare Advantage program.

Yet here we are, playing games with less than a week before physicians' Medicare reimbursements are scheduled to be cut, therapy services for some seniors will be ended, and billions of dollars that assist rural physicians and hospitals will be terminated. Once this bill fails today, we'll still be faced with the same expiring Medicare policies, but we will have one less day to fix them.

If anyone actually believes that this bill is a serious effort to fix these problems, they need only look to page 253 of the bill. Here you'll find a "Sense of the Senate" provision. Mr. Speaker, the last time I checked, this is the House of Representatives. This raises the question of whether, in their rush to bring this bill up for a vote, the Majority even read their own 278-page bill, which they introduced an hour ago, or if they simply copied the failed Senate bill word for word.

Well, my staff has read the bill, and here's what else they found. The bill cuts approximately $50 billion from Medicare Advantage. CBO predicts that more than 2 million seniors would lose access to their Medicare Advantage plan if this bill were enacted. The President has said repeatedly that he would veto any bill that contained these reductions. Thankfully, he won't have to, because the Senate already rejected these cuts two weeks ago.

Mr. Speaker, if the Majority was really serious about helping Medicare beneficiaries and providers, we would take up the compromise bill that Senators BAUCUS and GRASSLEY have worked out. That bill will eliminate the physician payment cuts in 2008 and 2009, extend rural payment add-ons and the existing exceptions process for therapy services and fully pay for these changes without changing the rules governing private fee for service plans. I believe that bill will pass the Senate, and then we in the House will have an opportunity, on a bipartisan basis, to protect physicians from the looming drastic cut in their reimbursement.

Mr. BARROW. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. I thank the gentleman for yielding, and I thank him for his leadership. I also want to thank Energy and Commerce Chair JOHN DINGELL and the Health Subcommittee Chairman FRANK PALLONE, as well as Chairmen RANGEL and STARK of the Ways and Means Committee for their continued leadership.

Last year, we passed the CHAMP bill to prevent a 10.6 percent cut in payments to Medicare providers and to make critical improvements, and today we are trying again. This bill would prevent physician payment cuts in 2008 and provide an increase in 2009. And, something of particular concern to me, it would address the cuts to mental health providers that have already taken place.

While we need to do more, we have to act now. And there are many, many reasons to support the passage of this bill. It provides mental health parity. It expands access to low-income assistance for seniors and people with disability struggling to pay their health care costs. It extends the moratorium on physical therapy caps. It eliminates cuts to oxygen treatment and wheelchairs. It postpones competitive bidding for durable medical equipment. On the diabetes front, it includes a 2-year reauthorization of the special diabetes program, prompt pay requirements for pharmacies, and on and on.

If you think it is more important to continue excess payments to private Medicare Advantage plans, plans that are getting 13 percent more than Medicare, you should vote no. In 2008, this meant that Medicare Advantage plans saw a 6 percent increase, while physicians are scheduled for a 10.6 percent cut. Next year, Medicare Advantage plans will see between a 5 and 7 percent increase, while physicians are scheduled for a 5 percent cut. But if you think it is more important to prevent Medicare cuts to physicians and providers and to help senior citizens and persons with disabilities, then you will vote yes.

I hope that all my colleagues on both sides of the aisle will make the right choice. I hope you will side with Medicare physicians and their patients and pass H.R. 6331.

Mr. BARTON of Texas. Mr. Speaker, can I inquire as to the time remaining on the four sides.

The SPEAKER pro tempore. The gentleman from Texas has 2½ minutes remaining; the gentleman from Georgia has 1½ minutes remaining; the gentleman from Michigan has 3 minutes remaining; and the gentleman from California has 3½ minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I have no other speakers, so I reserve the balance of my time and am prepared to close.

Mr. STARK. Mr. Speaker, I recognize the distinguished gentlewoman from California (Mrs. DAVIS) for a unanimous consent request.

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I join with the California Medical Association, the Center for Medicare Advocacy, the Clinical Social Work Association, the Federation of American Hospitals, the Food Marketing Institute and Kidney Care Partners in supporting H.R. 3631.

PARLIAMENTARY INQUIRY

Mr. CAMP of Michigan. Mr. Speaker, parliamentary inquiry. Is this coming out of the gentleman's time?

The SPEAKER pro tempore. A Member asking to insert remarks may include a simple declaration of sentiment for the question under debate, but should not embellish the request with extended oratory.

Mr. CAMP of Michigan. Mr. Speaker, the answer is yes?

The SPEAKER pro tempore. The Chair may charge time in the case of extended oratory.

Mr. CAMP of Michigan. I am sorry, could you repeat that?

The SPEAKER pro tempore. The Chair may charge time in the case of extended oratory.

Mr. CAMP of Michigan. I would certainly urge the Chair to charge time, because you have repeated extended oratories during this debate, and we would like the rules to be followed.

The SPEAKER pro tempore. The gentleman is correct.

Mr. STARK. I would like to yield 1 minute to the distinguished gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Mr. Speaker, I thank the gentleman for yielding and also for his leadership on this issue.

Mr. Speaker, today's vote is about maintaining access to health care for seniors and people with disabilities. Although this bill stops cuts to physician payments, it is not about how much we pay doctors. This bill is about access to health care for patients, people that need medical attention.

The data are convincing. Over 60 percent of California physicians would leave Medicare or stop taking new Medicare patients if these cuts are implemented. In rural California, like

rural America, we are already facing a physician shortage crisis. The impact on seniors would be devastating if Medicare beneficiaries lose access to thousands of physicians in California because of this cut.

Fortunately, we can prevent those cuts and further strengthen Medicare through expanded preventive health services, enhanced low income protections and other improvements to help people in need of care by passing H.R. 6331.

There may not be bipartisan support in this House for this bill, but there is bipartisan support across the country for this bill. I urge everyone to vote for it.

Mr. CAMP of Michigan. Mr. Speaker, I yield 1 minute to the distinguished member of the Ways and Means Committee, the gentleman from Texas (Mr. BRADY).

Mr. BRADY of Texas. Mr. Speaker, this bill offers a false choice between helping our physicians and our pharmacists, who need fair reimbursement, and helping our seniors, especially those in minority communities and those in rural communities from being able to see a doctor who they know and knows them.

Unfortunately, this Congress is full of false choices. In Texas, I know if we pass this bill, we have got over 800,000 seniors, mainly in rural communities and in very poor communities, who will not be able to see a doctor, will not be able to get the health care that they chose under Medicare, because this Congress has decided that they are going to pit those poor seniors against physicians and pharmacies in our communities. Those false choices is why this Congress has the lowest approval rating since they began taking polls.

Let's stop playing games with our doctors, let's stop playing games with our pharmacists, and let's stop playing games with the lives of our seniors. We can do better than this.

Mr. BARROW. Mr. Speaker, it is a pleasure for me to yield 1 minute to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. I thank my colleague.

Mr. Speaker, I rise in support of H.R. 6331. The alternative to this bill is a 10 percent pay cut for doctors who serve critical seniors and those with disabilities. Our doctors are desperate for this. It is emergency care. It is a band-aid approach, but at least it will stop the bleeding.

Last year we had a much better package, the CHAMP Act, which we did debate on this floor and which we did vote out. It hit a roadblock in the other body and at the White House. This bill at least ensures our physicians can continue practicing in our communities and serving the Medicare population.

I do want to mention two important items, a cost saving provision which will improve services for the Medicaid beneficiaries by expanding the numbers of patients who can be covered by the county organized health systems in Ventura and other counties in California. This is a proven way to provide cost-effective access to quality health care, and it has been in place in my County of Santa Barbara for many years.

I also want to commend the inclusion of E-Prescribing language. I was proud to work on this with my colleagues ALLYSON SCHWARTZ and JON PORTER. E-Prescribing will ensure prescriptions are transmitted safely.

I urge my colleagues to vote ''yes'' on this legislation.

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Mr. BARTON of Texas. I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I am pleased to yield 1 minute to the distinguished gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, when it comes to health care reform, my colleagues on the other side say the most important priority is the relationship between a patient and a doctor. Why isn't that true for seniors?

Today, our Republican friends are once again confronted with a simple choice: Stand with seniors and their physicians, or stand with the big insurance companies and tax cheats.

Seniors on Medicare are at risk of losing access to the doctor they know and trust. We have a plan to ensure that doesn't happen, and strengthen Medicare while doing it. Our plan stops overpayments to big insurance companies. We tell providers that owe billions in taxes that they cannot continue to cheat the taxpayers and go unpunished.

I know some of my colleagues on the other side of the aisle oppose this bill. Under their plan, seniors would go without care, tax cheats go unpunished, and insurance companies go to the bank. That is a tough argument to make here in Congress, and it is an even tougher argument to make to the American people.

I hope my Republican colleagues reconsider and lend their support to this legislation, which continues the relationship between seniors and their physician of choice.

Mr. CAMP of Michigan. Mr. Speaker, I reserve the balance of my time.

Mr. BARROW. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I am prepared to close if everybody else is prepared to close.

I yield myself the balance of my time.

The SPEAKER pro tempore. The gentleman is recognized for 2½ minutes.

Mr. BARTON of Texas. We do have a serious issue here, Mr. Speaker. We have known for several years that we needed to fix the current system for physician reimbursement. We also have known that in some of the other issues that have been put into this bill, that there are areas of reform that need to be implemented. One of the things that I have worked on for over 12 years is a competitive bidding process for durable medical equipment which is supposed to go into effect July 1 of this year. The pending bill has a moratorium on that implementation I believe for 18 months, which I think is ill-advised.

But I do think that when each of us gets elected to this body, when we go out and campaign and ask for Members and voters to support us, we don't say: If you vote for me, I will go to Washington and I will make sure that I have no input into major issues, and when they are put up at the last minute I will go vote ''yes'' on the suspension calendar. That is not what we say.

This is a serious issue. There are serious issues that need to be addressed in this bill. I am not sure this bill is even a House bill. My understanding is that it is a failed version of a Senate bill that has been patched together for purposes of a vote today just in case there is not a bipartisan compromise later in the week, as Congressman MCCRERY spoke about earlier.

Process does count. Policies are better if there is bipartisan input and you go through the give and take of subcommittee, full committee markup where stakeholders and Congressmen and women on both sides of the aisle can be involved. That has not happened here.

Again, this is a multibillion-dollar bill. Even if it were to be passed, it only has the effect for the rest of this year and the next calendar year. It is not a permanent fix. It doesn't address long term these issues. And all of the groups that are supporting the bill today that have been enunciated by the majority, when they have been in to see me they are talking about a permanent fixes, they are not talking about a temporary quick fix, patch it, go on down the road, kick the can fixes, which is what this is if it were to be implemented.

So I really hope that we can vote against this. Since it is a suspension vote, it only needs 146 ''no'' votes and it would fail, and then we could work together to perhaps on a permanent way fix some of these in a bipartisan way. So I urge a ''no'' vote.

Mr. STARK. Mr. Speaker, I yield myself the balance of my time, and urge my colleagues to support the bill.

The distinguished gentleman from Louisiana was quite correct; we have worked together on this. But for us now to depend on the other body is sheer folly. We quite have an idea of what they will send us, and it will be much less. There will be no prompt pay for pharmacists in the other body's bill. They will cut payment to oxygen providers and wheelchair providers. There will be less for low income seniors. There will be no preventative services. The only difference will be a slightly less cut to the private fee for service plans, and the administration actuaries have just recently sent us an e-mail saying this will extend the life of the Medicare trust fund.

And I apologize also to my distinguished ranking member on the Health Subcommittee, and I understand when we have 50 groups supporting our bill and you only have one, the lobbyists for the private fee for service plan, it gets a little annoying. But we will see if we can find one other group to support your bill. I doubt it, but we will try.

I urge this. This may be the last chance. I won't discuss process, but we all know that we cannot rely on the other body to come together and work as well as we have on a bipartisan basis.

Every part of this bill has had support on a bipartisan basis over the last year in this House. It is put together to get as much as we can for as little cost to the providers, to extend benefits to the seniors, to provide preventative care, to give mental health parity, and pay the doctors what they are entitled to. Please support the bill, and let us finish our work this week.

Mr. CAMP of Michigan. Mr. Speaker, I yield myself such time as I may consume.

I would just say, if we are really worried about cuts to physicians, why bring up a bill that has already failed in the Senate?

And frankly, I would say to my good friend that every person or group that supports this bill will also support the bipartisan Senate bill that is going to come over from the Senate later this week.

And let me just say, if anyone actually believes still that this bill is a serious effort to fix these problems, they need only look to page 253 of the bill. As my friend from Texas pointed out, this is the group that left a whole section out of the farm bill so we had to revote on it a second time. But here we will find a ''Sense of the Senate provision.'' And, Mr. Speaker, the last time I checked, this is the House of Representatives. And this really raises the question of whether in the rush to bring this bill up for a vote the majority even read their own 278 page bill because they introduced it at about 10:00, 2 hours ago, or if they just simply copied the Senate bill word for word.

So, frankly, I think if we could look at the Senate bill that I just got an e-mail that their bipartisan issue is imminent, that they are working and they are close to a deal. This could have happened in the House as well if the majority had decided to honestly debate this issue.

So I urge my colleagues to vote ''no'' on this bill that is dead before it even arrived, as it has already failed in the Senate.

At this time I yield back the balance of my time.

Mr. BARROW. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, we have until July 1 to stop these cuts from taking effect. Unless we adopt this legislation before then, doctors all across the country will start turning away Medicare patients. We cannot let that happen.

I want to thank the distinguished chairman of the Committee on Energy and Commerce for his leadership on this matter. I urge my colleagues to support this bill.

Mr. ENGEL. Mr. Speaker, I rise today in strong support for H.R. 6331, the ''Medicare Improvements for Patients and Providers Act of 2008.''

As a senior member of the Health Subcommittee of the House Energy and Commerce Committee, I have worked hard throughout my career in Congress to pass commonsense healthcare measures. I am proud to have worked with my colleagues on the underlying legislation. H.R. 6331 prevents the pending 10 percent payment reduction for physicians in Medicare, enhances Medicare preventive and mental health benefits, and improves and extends programs for low-income Medicare beneficiaries.

Our physicians are the backbone of our communities and we must guarantee that they are fairly compensated for the good work they do. By eliminating the physician payment reduction and through the other measures included in H.R. 6331, we can ensure our patients' continued access to quality care.

Mr. Speaker, I am deeply trouble by some of the rhetoric on the other side of the aisle. It is absolutely disgraceful that the Republican leadership has been urging a ''no'' vote in part because we are strengthening the Medicare program in this bill. There have been comments from the Republican side opposing the expansion of the Medicare Savings Program, MSP, in this bill—a program specifically designed to provide a extra assistance to low-income seniors who desperately need it. Republicans also oppose he expansion of Medicare's coverage of preventive services in this bill. We all know that improving access to quality health care, such as by providing preventive services will save millions of Medicare dollars down the line. It is backwards thinking to simply wait till seniors' healthcare erodes beyond repair before we take action.

Democrats will stand by our Medicare beneficiaries and doctors and vote ''yes'' on H.R. 6331 today. Republicans should do the same. Anything different is simply unconscionable.

Mrs. JONES of Ohio. Mr. Speaker, I rise in support of the Medicare Improvements for Patients and Providers Act of 2008. This legislation prevents the pending 10-percent payment reduction for physicians in Medicare, enhances Medicare preventive and mental health benefits, improves and extends programs for low-income Medicare beneficiaries, and extends expiring provisions for rural and other providers.

While I do have some concerns regarding the lack of protections for African American end stage renal disease patients, I am encouraged by many of the provisions included in this legislation. I am particularly pleased that the bill extends and improves low-income assistance programs for Medicare whose income is below $14,040.00 including the qualified individual program that pays part B premiums for low-income beneficiaries. Additionally, the bill adds new preventative benefits to the Medicare program and reduces out of pocket expenses for mental health care.

Specifically, provisions of the legislation include modest steps to reduce Medicare payments to private plans that receive more than 100 percent of the cost to treat a beneficiary in fee-for-service Medicare. The legislation would accomplish this by phasing out the Indirect Medical Education double-payment, eliminating the Medicare ''slush'' fund to further increase payments to private plans, and ensuring that Private Fee-for-Service, PFFS, plans comply with quality requirements and have adequate access to providers.

Additionally, the legislation provides assistance to physicians and pharmacies including eliminating the pending 10-percent cut in Medicare payments to physicians through 2008, a 1.1 percent update in Medicare physician payments for 2009, and requires Medicare Advantage plans to pay pharmacies promptly within a 14-day period.

Mr. KLEIN of Florida. Mr. Speaker, I rise in support of H.R. 6331, the ''Medicare Improvements and Patients and Providers Act of 2008,'' and thank Chairmen RANGEL and DINGELL for their leadership in bringing it to the House floor today. This legislation, among other things, will block a devastating 10.6 percent cut in reimbursement fees for physicians who accept Medicare patients.

Mr. Speaker, Medicare used to be known as the ''Gold Standard'' for physicians because it provided them with fair and sustainable reimbursement rates, but not anymore. As a result of the President trying to balance the budget on the backs of doctors, physicians all across the country are facing severe cuts in their Medicare reimbursements on July 1.

In south Florida, we're currently facing a severe shortage of qualified physicians in part because of the way physicians are paid under Medicare, and the pending cut could hasten this exodus, potentially leaving many elderly and other vulnerable populations without doctors to treat them.

This is an unacceptable situation for south Florida or for any region of this country. Eliminating the cuts and providing physicians with a 1.1 percent increase in 2009 is simply the right thing to do.

But we cannot be satisfied with short-term patches to this systemic problem. During the next 18 months, let us once and for all end all talk of patches or fixes, and come together in a bipartisan way to find a permanent solution to the way we pay our doctors.

We owe it to our seniors, to the men and women who helped to make this country the greatest in the world, to ensure that when they are sick, a doctor will be there to see them. It's a fair deal, and one we must not turn our backs on.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in strong support of H.R. 6331, the ''Protecting the Medicaid Safety Net Act of 2008.'' I would like to thank my colleague from New York, Chairman CHARLES RANGEL for his leadership in this important issue.

This legislation could not come at a more crucial time. Americans are in need of support. Rising gas prices, food costs at an all-time high, and a rocky housing market have pushed this great Nation towards an economic downturn. Families are clinging to basic necessities and quality healthcare is one of those essential needs.

I am pleased to see that there is no language that inhibits physician ownership of general acute care hospitals. I have worked tirelessly with Members of leadership and with the Texas delegation to support general acute-care hospitals and their future development. Physicians who have decided to build in areas

where often no other hospital will—should not be penalized for their commitment to work on the clinical and business side of health care.

General acute-care hospitals still need to be able to: maintain a minimum number of physicians available at all times to provide service; provide a significant amount of charity care; treat at least 1/6 of their outpatient visits for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; maintain at least 10 full-time interns or residents-in-training in a teaching program; advertise or present themselves to the public as a place which provides emergency care; serve as a disproportionate share provider, serving a low income community with a disproportionate share of low income patients; and have at least 90 hospital beds available to patients.

This issue is of the utmost importance to me because I, like others in the Democratic Caucus, have hospitals and hospital systems such as University Hospital Systems of Houston in my district that would have been greatly affected by this provision.

For example, 2 years ago, St. Joseph Medical Center, downtown Houston's first and only teaching hospital, was on the verge of closing its doors. However, a hospital corporation in partnership with physicians purchased it, and as a result of proper and responsible management, has made it the premier hospital in the region, with a qualified emergency room responsive to a heavily populated downtown Houston. St. Joseph Medical Center is also in the process of reopening Houston Heights Hospital, the fourth oldest acute care hospital in Houston. This hospital will be serving a large Medicare/Medicaid population.

I am committed to this issue and to the issue of health care for all Americans. Provisions that could end the expansion of truly compassionate hospital care in places like Texas, Maryland, New York and California have no place in healthcare legislation.

What I do support is legislation that seeks to aid our elderly, our disabled, our veterans, our children and our indigent populations. I stand here today to show my support not only for the physicians and medical care providers of Houston, Texas, but for all of our healthcare providers across this country. We need them to continue to be able to care for our underserved and elderly—this bill allows them to do just that.

This bill provides a delay of 18 months for the competitive bidding program for Durable Medical Equipment, DMEPOS. It also prevents the 10.6 percent pay cut to physicians that is scheduled to take place on July 1, and provides a 1.1 percent update starting January 1, 2009.

This bill also includes important beneficiary improvements such as Medicare mental health parity, improved preventive coverage, and enhanced assistance for low-income beneficiaries.

It contains provisions that will protect the fragile rural health care safety net. In my home State of Texas, we have not only great urban areas such as Houston, Dallas and Austin, we have over 300 rural areas in Texas with cities such as Rollingwood and Hamilton.

Our rural health care providers are scheduled to receive steep cuts in Medicare reimbursement rates on July 1 unless we take action now. Such cuts are catastrophic in rural America, where a disproportionate number of elderly Americans live. These seniors are, per capita, older, poorer and sicker (with greater chronic illnesses) than their urban counterparts. Additionally, recruitment and retention of providers to much of rural America is often daunting. Provider shortages are rampant throughout many rural and most frontier regions.

Additionally, H.R. 633 also includes several other critical provisions for rural providers which, cumulatively, create a rural package that will help protect both the rural health safety net and the health of tens of millions of seniors who call rural America home.

H.R. 6331 focuses on strengthening primary care and takes significant strides in protecting rural seniors' access to care by correcting certain long-standing inequities between rural and urban providers.

Thank you both for your continued concern for the health of rural Americans. So many enduring inequities in health care must be faced by rural patients and providers daily. H.R. 6331 offers critical assistance and will go far to improving the health of millions of rural Medicare beneficiaries.

Quality measures must continue to be adequately funded in order to promote quality, cost-effective health care for consumers and employers. The uncertainty of Medicare payments makes it increasingly difficult for surgeons and their practices to plan for the expenses that they will incur as they serve their patients.

The provisions included in H.R. 6331 would enable surgeons and surgical practices to plan for the rising costs that they will continue to face over the next year and a half.

By addressing payment levels through 2009, Chairman RANGEL has given us more time to study the payment issues surrounding Medicare and allow us to look at the systemic reforms needed to preserve access to quality surgical care and other physician services.

As a long-time advocate for universal health care, I believe we must continue to support our essential medical providers so that they can focus on patient care. We need more physicians as we seek to expand health care for all Americans. Yet, how can we expect to grow that workforce when we continue to cut their reimbursement levels? We must support our physicians so that they may support and care for their patients. We have to continue to look at how we can save Medicare and expand it to care for those who need it most.

I am proud to cosponsor legislation that will add support for our healthcare workforce. I urge my colleagues to join me in supporting this legislation.

Mr. VAN HOLLEN. Mr. Speaker, I rise in strong support of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008.

Most importantly, this legislation prevents the impending 10 percent cut in Medicare payments to physicians for the remainder of 2008 and provides a 1.1 percent update in physician payments for 2009. The uncertainty of Medicare payments makes it difficult for physicians and their practices to plan for the expenses that they will incur as they serve Medicare beneficiaries. And in turn, beneficiaries will face increasing difficulties accessing physicians who accept Medicare. What we need to do is address this issue in the long term by reforming the flawed reimbursement formulas. By addressing this issue in the short term through 2009, we will provide Congress with the needed time to study and develop a long term solution to this problem.

Not only would we prevent cuts in Medicare physician reimbursements, the bill will make important and necessary improvements to the Medicare program by enhancing Medicare preventative and mental health benefits, improving assistance for low-income Medicare beneficiaries, and extending expiring provisions for rural and other providers.

And this legislation is fully paid for. It reduces Medicare Advantage Indirect Medical Education IME, overpayments, which are being paid twice: once to the teaching facility itself, and again to Medicare Advantage plans, with no requirement that plans pass the IME payment along to the teaching facility. H.R. 6331 will eliminate the needless double payment by still reimbursing the teaching facility directly for the higher cost of care, but ceasing IME payments to Medicare Advantage plans.

I am pleased that this legislation contains a provision that makes a technical correction to ensure that all physicians, including podiatrists, are permitted to perform required face-to-face examinations so that they are able to prescribe Medicare-covered durable medical equipment, prosthetics, orthotics and supplies, DMEPOS. This provision corrects a drafting error in the 2003 Medicare Modernization Act that pointed to the wrong definition of physician in the Social Security Act when requiring face-to-face examination in order to prescribe DMEPOS items.

I am also pleased that the bill includes a two-year reauthorization of the Special Diabetes Programs for Type 1 Diabetes and the Special Diabetes Programs for Native Americans at current funding levels. It is vital that this successful program be reauthorized on a multi-year basis so that the National Institutes of Health, NIH, can invest in new research. Without this reauthorization, NIH would have to begin to shut down research projects that are currently underway.

Mr. Speaker, we owe it to provide and beneficiaries to make these modest improvements to the Medicare program now. This bill will protect our seniors. The clock is ticking. I urge my colleagues to support this much-needed legislation.

Mr. BLUMENAUER. Mr. Speaker, today I am proud to support H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. This legislation addresses issues within Medicare that have been too long ignored, including preventing the pending 10 percent payment reduction for, enhancing preventive and mental health benefits, improving and extending programs for low-income Medicare beneficiaries, and extending expiring provisions for rural providers.

By addressing the critical issue of physician payment under Medicare through 2009, Congress will have the time to study and develop the systemic, sustainable reforms necessary to preserve patient access to physician services under Medicare. And the 18-month delay in implementation of the flawed competitive bidding program for Durable Medical Equipment, DMEPOS, allows Congress time to evaluate and improve this policy.

I am heartened this legislation passed with such overwhelming bipartisan support, demonstrating that we can come together with thoughtful solutions that better the lives of Americans.

Mr. FARR. Mr. Speaker, I would like to add my comments for the record on this Medicare bill that we debate today.

Yes, it is a critical bill. It will prevent a 10.6 percent cut in payments to doctors who treat America's senior citizens, the wide network of doctors in the Medicare system. In addition, it shores up those payments with a 1.1 percent payment increase in 2009.

But though I applaud what is in this bill, I bemoan what is not in the bill.

The negotiators on this bill have heard from me—and others—long and loud about the flaws in the formula that determines Medicare doctor fees. In a number of States across the country the formula knowingly and erroneously designates some areas as being rural in nature when they are by all other definitions clearly urban. The result of this deliberate misclassification is to pay doctors at low rural reimbursement rates rather than at their true costs of operating a medical practice in a high-end urban setting.

Doctors in my district and 9 other counties in California are paid upwards of 10 to 12 percent less than the law—yes, the law—says they ought to be paid. But because the Centers for Medicare and Medicaid Services, CMS, won't make the necessary technical formula adjustment in a factor called the Geographic Practice Cost Index or GPCI, these doctors are underpaid. Doctors in Santa Cruz, Sonoma, Monterey, San Diego, Santa Barbara, Sacramento, El Dorado, Marin, and San Benito counties in California are mistreated by CMS. But nothing in the bill we debate today will help them.

Previously this House did take a step to correct this inequity. In H.R. 3162, the original CHAMP bill that we passed last summer, Section 308 fixed the GPCI factor. But despite my efforts and those of my colleagues from affected counties throughout California and in similarly impacted States of New York, Texas and elsewhere, H.R. 6331 maintains the flawed formula and perpetuates the clear disparities of this CMS payment policy. Even the GAO in its report last year, GAO–07–466, showed that without a doubt the CMS formula did not fairly compensate doctors and needed serious reform. Despite mountains of evidence and years of engaging the Ways and Means Committee on this issue, H.R. 6331 ignores an opportunity to do what's right by these doctors.

I am not going to vote against this bill. But I have to say that it is a sad day when this House votes to pass a doctor payment reform bill that only reforms doctor payments for some and not for all.

Mr. ETHERIDGE. Mr. Speaker, I rise in strong support of H.R. 6331, The ''Medicare Improvements for Patients and Providers Act of 2008.'' This bill fulfills America's promise to its seniors and disabled citizens, protecting access to high quality health care without unreasonable costs.

For more than 40 years, Medicare has helped meet the needs of many vulnerable Americans. It cannot continue to do so if providers are paid unreasonable reimbursements, if rules hinder quality patient care, or if the burden of paperwork and payment delays keeps small businesses out of the health care market. This bill ensures physicians, pharmacists, durable medical equipment suppliers, and other health care providers can continue to support the health and well being of Medicare beneficiaries in many ways.

H.R. 6331 will ensure health care is available in rural areas of this country, like those in the Second District of North Carolina. By replacing a 10 percent cut in pay with a slight increase, it ensures doctors can afford to stay in business wherever they choose to practice medicine. By improving payments to hospitals that provide care where no other provider is available, and by making sure rural hospitals are paid equally for clinical services, it ensures those services are available throughout the country. By increasing access to telehealth, it expands the reach of professional advice beyond the doctor's office.

H.R. 6331 is also a boon for small businesses. The vast majority of medical providers are small businesses, and by ensuring they can afford to provide care we support the engine of our economy. Especially in rural areas, our small community pharmacies and medical equipment suppliers are the face of medicine for many Medicare beneficiaries. Health care is improved when people know their providers, and this makes them more likely to comply with medical directives. I am pleased that H.R. 6331 includes several provisions for these small suppliers that I have advocated for some time, including prompt payment provisions and a delay in rules from the Centers for Medicare and Medicaid Services, CMS. Before proceeding, we need to be sure that these initiatives, including competitive bidding for durable medical equipment and the implementation of the Average Manufacturing Price, AMP, system, help to preserve and improve patient care by allowing community suppliers to remain open so that they may continue to serve, and, more importantly, operate at a level that facilitates the provision of the best possible, safest medical care.

Mr. Speaker, this legislation improves the health and health care of Medicare beneficiaries, the ability of medical professionals to provide that care, and the quality of medical care throughout our country. I urge my colleagues to join me in supporting H.R. 6331.

Mr. ABERCROMBIE. Mr. Speaker, I rise today in support of H.R. 6331, the ''Medicare Improvement for Patients and Providers Act of 2008.'' This bill makes some important changes in the Medicare program that help assure access for our seniors to quality medical care.

The bill defers the 10.6% cut in physician reimbursements mandated by the Sustainable Growth Rate (SGR) that would go into effect on July 1, 2008. Instead, the bill continues the present reimbursement rate for 18 months and then increases it by 1.1%.

The bill also provides important improvements for our senior citizens, increasing the allowable income and asset maximums for premium assistance. The co-payments for mental health services are reduced from 50% to 20%, the same as any other doctor visit.

The legislation addresses problems within Medicare to pay for these benefits, reforming the system that overpays to Medicare Advantage (MA) plans, private plans that operate within Medicare, which cost the government on average 12% more than traditional services. The bill will also require that any delinquent taxes owed by Medicare providers be deducted from their Medicare reimbursements.

In addition to improving Medicare services, the legislation also makes important changes to Medicaid, including a provision that is particularly vital for the people of Hawaii: Disproportionate Share Hospital (DSH) payments.

Following an oversight in the Balanced Budget Act of 1997, only Hawaii and Tennessee have not received DSH payments in Medicaid, which provide additional support to hospitals that treat large numbers of Medicaid and uninsured patients. This bill provides a temporary remedy, which will help keep these hospitals open.

I have been working with Senator DANIEL AKAKA, the Hawaii Delegation and my colleagues on the Committee on Energy and Commerce to ensure that Hawaii and Tennessee receive equal treatment in the matter of DSH payments from the Federal Government. H.R. 6631 extends DSH payments for Hawaii and Tennessee through December 31, 2009, and provides an additional $15 million for Hawaii. This extension authorizes the submission by the State of Hawaii of a State plan amendment covering a DSH payment methodology to hospitals which is consistent with the requirements of existing law. The purpose of providing a DSH allotment for Hawaii is to provide additional funding to the State of Hawaii to permit a greater contribution toward the uncompensated costs of hospitals that are providing indigent care. It is not meant to alter existing arrangements between the State of Hawaii and the Centers for Medicare and Medicaid Services (CMS) or to reduce in any way the level of Federal funding for Hawaii's QUEST program.

I will continue to work toward a permanent solution to the DSH matter, but until then, I urge my colleagues to support this measure. It is not an earmark, but merely provides Hawaii and Tennessee equity with everyone else.

Again I want to thank Chairman RANGEL, Chairman DINGELL, Chairman PALLONE, and Chairman STARK on this important piece of legislation that protects our seniors and provides equity for the State of Hawaii. I urge my colleagues to pass this vital bill.

Mr. POMEROY. Mr. Speaker, I rise in strong support of H.R. 6331, the Medicare Improvements for Patients and Providers Act, legislation that strengthens the Medicare Program and maintains our commitment to rural America.

Rural America continues to be challenged by shortages of health care providers, barriers to health care access, and geographic isolation. In my own home State of North Dakota, approximately 80 percent of the State is designated as a partial or full county Health Professional Shortage Area. In order to address these unique challenges, the Medicare Modernization Act, MMA, enacted special payment enhancements to make sure that rural health care facilities and providers have the resources they need to deliver quality care in their communities.

Unfortunately, many of these important provisions are set to expire and further assistance is needed to ensure that seniors living in rural America have access to quality, affordable health care. That is why I introduced H.R. 2860, the Health Care Access and Rural Equity, H–CARE, Act, bipartisan legislation that addresses these and other barriers to quality health care by recognizing the unique characteristics of health care delivery in rural areas and assisting rural health care providers in their efforts to continue to provide quality care to rural Americans.

I am pleased that the Medicare Improvements for Patients and Providers Act, MIPPA,

of 2008 incorporates many important provisions from H–CARE that will do much to protect the fragile rural health care safety net. More specifically, MIPPA will do the following:

Reauthorize and expand the FLEX Grant Program to include a new grant program that could mean up to $1 million to Richardton, North Dakota, as they convert from their status as a Critical Access Hospital;

Extend Section 508 of the Medicare Modernization Act which provides nearly $10 million a year to North Dakota hospitals to give them the resources they need to compete in an increasingly competitive labor market;

Ensure that rural doctors are paid the same rate for their work as their urban counterparts by extending the 1.0 work floor on the Medicare work geographic adjustment applied to physician payments bringing in $9 million to North Dakota through 2009;

Improve Medicare reimbursements for Critical Access Hospitals by directly increasing payments for critical lab services such as blood testing and other diagnostic services;

Boost reimbursements to sole community hospitals by updating the data used to calculate their Medicare reimbursements;

Protect access to rural ambulance services by providing rural ambulance providers an additional 3 percent of their Medicare reimbursement in order to help cover their costs;

Require prompt payment to rural pharmacies by Medicare prescription drug plans;

Extend a provision that allows 19 North Dakota hospital-based labs to directly bill Medicare for pathology services; and

Expand access to telehealth services by allowing hospital-based renal dialysis facilities, skilled nursing facilities, and community mental health centers to be reimbursed under Medicare for telehealth services.

I would also like to express my appreciation of the Chairman's consideration of technical corrections to recently enacted reforms to the Long Term Care Hospital payment system under Medicare and I look forward to continuing to work with him to resolve this issue.

Medicare Improvements for Patients and Providers Act is a good bill that has been endorsed by the National Rural Health Association and deserves every Members' support.

Mr. BACA. Mr. Speaker, I rise today to support of H.R. 6331, the Medicare Improvements for Patients and Providers Act.

My top priorities are the patients and their families from my District.

Over the past several months, I've received several phone calls from hard-working families. These families are worried whether the Medicare physician payment cuts will prevent them from being able to see their doctor.

These families are worried about their ability to receive life saving medicines and medical supplies in the mail next time they run out.

These families are worried about their local pharmacy's ability to offer discounts on medicines.

For these families, I stand here in support of H.R. 6331.

This bill delays physician payment cuts, protecting our seniors from facing difficulty in accessing needed healthcare. In these times of skyrocketing gas prices, this bill improves low-income assistance programs for Medicare beneficiaries. Many working families from the Inland Empire, in California, are faced with putting food on the table or paying for medicines.

Furthermore, my constituents will face a unique situation when the competitive bidding process rolls out on July 1st. This bill delays this process; preventing any possible harmful interruptions in the shipment of medical supplies to patients.

Time is quickly running out, these deadlines are approaching and we must not stand by and watch.

I urge my colleagues to vote for H.R. 6331, our working families are counting on us.

Mr. CONYERS. Mr. Speaker, I rise to voice my strong support for H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. This important legislation amends titles XVIII and XIX of the Social Security Act to extend, for 18 months, expiring provisions under the Medicare Program. This critical bill prevents the implementation of a scheduled 10.6 percent cut in Medicare reimbursements for physicians and other health care professionals, and extends the 0.5 percent payment update for 2008 and provides a 1.1 percent payment increase for physicians in 2009.

Cutting funds to Medicare, in any way, threatens to up heave the very system that millions of Americans rely upon to provide life saving medical care and services. It boggles the mind to think that, with an aging population and a worsening physician shortage, we would even consider cutting reimbursement rates to our hard-working physicians who care for millions of Medicare patients across the country. If these cuts were allowed to go into effect, many physicians would opt out of accepting Medicare, and would therefore be unable to provide necessary medical services to our seniors.

Mr. Speaker, we are in the midst of a bona fide health care crisis. One-in-three Americans either have either no health insurance whatsoever, or have insurance that is so inadequate that it can potentially lead to financial ruin. For those lucky enough to have survived these misadventures in our fragmented non-system of care, Medicare and Medicaid is their singular saving grace.

Allowing Medicare to unravel before our eyes is unacceptable. It, along with Medicaid, represents a lone island in a sea of broken services representative of our fragmented, non-system of health care. We must not only keep Medicare afloat, but improve and expand its ideals and principals if we are to ever truly provide quality health care to all.

Mr. Speaker, passage of H.R. 6331 is simply a necessity. However, we as a Congress must confront head-on the looming health care crisis and make the difficult decisions our constituents expect us to make. Revising the Sustained Growth Rate Formula, which is used to set Medicare's physician payment rate, represents only a portion of reforms which are needed to ensure that our seniors are cared for in the sunset of their lives. Patch-work fixes and temporary solutions are no substitution for real answers to difficult problems. After all, what we put off today must be dealt with tomorrow.

Mr. LANGEVIN. Mr. Speaker, I rise in support of H.R. 6331, the Medicare Improvement for Patients and Providers Act of 2008. I am pleased that the House of Representatives is taking action to address some immediate concerns within the Medicare program. This matter has regrettably become stalled in the Senate, and passage of this bill will affirm our commitment to ensuring continued access to care for America's Medicare beneficiaries.

This measure includes a number of important provisions, including increased access to low income assistance, additional supports for rural providers and beneficiaries, and an extension of access to therapy services through 2009. Additionally, this bill delays the impending 10.6 percent cut in Medicare physician reimbursements scheduled to take effect on July 1, 2008. Instead, it freezes payments for the remainder of 2008 and provides a modest 1.1 percent increase in 2009. This legislative fix, although temporary, will help ensure that access to care is not compromised and physicians can continue serving our most vulnerable populations. It is my hope that Congress will use these next 18 months as an opportunity to find a permanent and sustainable solution for the flawed reimbursement formula so that it more accurately represents the costs of providing care in the current market.

Also included in this bill is a provision to delay Medicare's competitive bidding program for durable medical equipment. Although competitive bidding was instituted to reduce spending within the already overburdened Medicare system, serious concerns have been raised over the implementation and potential consequences of this program. H.R. 6331 halts the implementation of the competitive bidding program for one year, while making necessary improvements to the bidding process and establishing quality standards for suppliers. This will constitute an important step towards a more efficient system that maintains the quality and access that beneficiaries deserve.

Americans everywhere are counting on this Congress to take action before July 1, to ensure that access to Medicare services is not jeopardized. I urge my colleagues to support this bill so that lawmakers can begin to discuss long-term, viable solutions to reform and stabilize the Medicare program.

Mr. MILLER of California. Mr. Speaker, this is a very important bill that will prevent the pending payment reduction of 10 percent for physicians in Medicare, enhance Medicare preventive and mental health benefits, and includes many important improvements to the Medicare program to the benefit of our constituents.

I strongly support the legislation.

Mr. BARROW. I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CAPUANO). The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 6331, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. BARTON of Texas. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 355, nays 59, not voting 20, as follows:

[Roll No. 443]

YEAS—355

Abercrombie
Ackerman
Aderholt
Alexander
Allen
Altmire
Andrews
Arcuri
Baca
Bachus
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blumenauer
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boyd (FL)
Boyda (KS)
Brady (PA)
Braley (IA)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Buchanan
Burgess
Burton (IN)
Butterfield
Calvert
Capito
Capps
Capuano
Cardoza
Carnahan
Carney
Carson
Castle
Castor
Cazayoux
Chabot
Chandler
Childers
Clarke
Clay
Cleaver
Clyburn
Coble
Cohen
Conyers
Cooper
Costa
Costello
Courtney
Cramer
Crowley
Cubin
Cuellar
Cummings
Davis (AL)
Davis (CA)
Davis (KY)
Davis, David
Davis, Lincoln
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly
Doyle
Drake
Dreier
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emanuel
Emerson
English (PA)
Eshoo
Etheridge
Everett
Fallin
Farr
Fattah
Feeney
Ferguson
Filner
Forbes
Fortenberry
Fossella
Foster
Foxx
Frank (MA)
Gallegly
Gerlach
Giffords
Gilchrest
Gillibrand
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Graves
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Hall (TX)
Hare
Harman
Hastings (FL)
Hastings (WA)
Hayes
Heller
Herseth Sandlin
Hill
Hinchey
Hinojosa
Hirono
Hobson
Hodes
Hoekstra
Holden
Holt
Honda
Hooley
Hoyer
Hunter
Inglis (SC)
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (GA)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kagen
Kanjorski
Kaptur
Keller
Kennedy
Kildee
Kilpatrick
Kind
King (NY)
Kingston
Kirk
Klein (FL)
Kline (MN)
Knollenberg
Kucinich
Kuhl (NY)
LaHood
Lampson
Langevin
Larsen (WA)
Larson (CT)
Latham
LaTourette
Latta
Lee
Levin
Lewis (CA)
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Lucas
Lynch
Mack
Mahoney (FL)
Maloney (NY)
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCaul (TX)
McCollum (MN)
McCotter
McDermott
McGovern
McHugh
McIntyre
McKeon
McMorris Rodgers
McNerney
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (KS)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murphy, Tim
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor
Payne
Pearce
Perlmutter
Peterson (MN)
Petri
Pickering
Platts
Poe
Pomeroy
Porter
Price (GA)
Price (NC)
Putnam
Rahall
Ramstad
Rangel
Regula
Rehberg
Reichert
Richardson
Rodriguez
Rogers (AL)
Rogers (KY)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Ruppersberger
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schmidt
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shays
Shea-Porter
Sherman
Shuler
Shuster
Simpson
Sires
Skelton
Slaughter
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Space
Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tanner
Tauscher
Taylor
Terry
Thompson (CA)
Tiahrt
Tiberi
Tierney
Towns
Tsongas
Turner
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walberg
Walden (OR)
Walsh (NY)
Walz (MN)
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch (VT)
Weldon (FL)
Weller
Wexler
Whitfield (KY)
Wilson (NM)
Wilson (OH)
Wilson (SC)
Wittman (VA)
Wolf
Woolsey
Wu
Yarmuth
Young (AK)
Young (FL)

NAYS—59

Akin
Bachmann
Barrett (SC)
Bartlett (MD)
Barton (TX)
Blackburn
Blunt
Boehner
Boustany
Brady (TX)
Broun (GA)
Buyer
Camp (MI)
Campbell (CA)
Cantor
Carter
Cole (OK)
Conaway
Crenshaw
Culberson
Doolittle
Duncan
Flake
Franks (AZ)
Frelinghuysen
Garrett (NJ)
Granger
Hensarling
Herger
Hulshof
Johnson, Sam
Jordan
King (IA)
Lamborn
Lewis (KY)
Linder
Lungren, Daniel E.
Marchant
McCrery
McHenry
Mica
Neugebauer
Paul
Pitts
Radanovich
Renzi
Rogers (MI)
Roskam
Royce
Ryan (WI)
Sali
Scalise
Sensenbrenner
Sessions
Shadegg
Shimkus
Smith (NE)
Thornberry
Westmoreland

NOT VOTING—20

Bishop (UT)
Cannon
Davis (IL)
Engel
Gohmert
Higgins
Johnson (IL)
McNulty
Miller, George
Nunes
Pence
Peterson (PA)
Pryce (OH)
Reyes
Reynolds
Rush
Saxton
Speier
Tancredo
Thompson (MS)

□ 1236

Mr. DANIEL E. LUNGREN of California changed his vote from ''yea'' to ''nay.''

Messrs. CHABOT, WHITFIELD of Kentucky, FRANK of Massachusetts, GRAVES, HASTINGS of Washington, WELLER of Illinois, LATTA, FARR, Mrs. MYRICK, Messrs. GALLEGLY, REICHERT, Mrs. MILLER of Michigan, Messrs. McKEON, MANZULLO, MILLER of Florida, BOOZMAN, WILSON of South Carolina, MACK, DREIER, ISSA, CALVERT, HALL of Texas, Mrs. DRAKE, Messrs. HUNTER, ROGERS of Kentucky, GARY G. MILLER of California, McCAUL of Texas, KLINE of Minnesota, RAMSTAD, Mrs. McMORRIS RODGERS, Ms. FALLIN, Messrs. KINGSTON, DEAL of Georgia, and BROWN of South Carolina changed their vote from ''nay'' to ''yea.''

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. GEORGE MILLER of California. Mr. Speaker, because I was chairing a hearing today on whether OSHA is failing to adequately enforce construction safety rules, I was unable to vote on the Medicare Improvements for Patients and Providers Act of 2008, H.R. 6331.

I strongly support the legislation, and I would have voted in favor of H.R. 6331 had I been present during the vote.

FEDERAL AVIATION ADMINISTRATION EXTENSION ACT OF 2008

Mr. NEAL of Massachusetts. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6327) to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 6327

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 ''Federal Aviation Administration Extension Act of 2008''.

SEC. 2. EXTENSION OF TAXES FUNDING AIRPORT AND AIRWAY TRUST FUND.

(a) FUEL TAXES.—Subparagraph (B) of section 4081(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''June 30, 2008'' and inserting ''September 30, 2008''.

(b) TICKET TAXES.—

(1) PERSONS.—Clause (ii) of section 4261(j)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''June 30, 2008'' and inserting ''September 30, 2008''.

(2) PROPERTY.—Clause (ii) of section 4271(d)(1)(A) of such Code is amended by striking ''June 30, 2008'' and inserting ''September 30, 2008''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on July 1, 2008.

SEC. 3. EXTENSION OF AIRPORT AND AIRWAY TRUST FUND EXPENDITURE AUTHORITY.

(a) IN GENERAL.—Paragraph (1) of section 9502(d) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''July 1, 2008'' and inserting ''October 1, 2008'', and

(2) by inserting ''or the Federal Aviation Administration Extension Act of 2008'' before the semicolon at the end of subparagraph (A).

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 9502(e) of such Code is amended by striking the date specified in such paragraph and inserting ''October 1, 2008''.

(c) EXTENSION OF EXPIRING AVIATION PROGRAM AUTHORITY.—

(1) Section 40117(l)(7) of title 49, United States Code, is amended by striking ''the date that is 3 years after the date of issuance of regulations to carry out this subsection.'' and inserting ''September 30, 2008.''.

(2) Section 47141(f) of title 49, United States Code, is amended by striking ''September 30, 2007.'' and inserting ''September 30, 2008.''.

(3) Section 161 of the Vision 100—Century of Aviation Reauthorization Act (49 U.S.C. 47109 note) is amended by striking ''fiscal year 2008 before July 1, 2008.'' and inserting ''fiscal year 2008.''.

(4) Section 186(d) of the Vision 100—Century of Aviation Reauthorization Act (Pub. L. No. 108–176, 117 Stat. 2490, 2518) is amended by striking ''October 1, 2007, and for the portion of fiscal year 2008 ending before July 1, 2008,'' and inserting ''October 1, 2008,''.

(5) Section 47115(j) of title 49, United States Code, is amended by striking ''fiscal years