212, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. ACKERMAN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 212, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 426, nays 0, not voting 8, as follows:

[Roll No. 906]

YEAS—426

Abercrombie	Clyburn	Grijalva
Ackerman	Coble	Guthrie
Aderholt	Coffman (CO)	Gutierrez
Adler (NJ)	Cohen	Hall (NY)
Akin	Cole	Hall (TX)
Alexander	Conaway	Halvorson
Altmire	Connolly (VA)	Hare
Andrews	Conyers	Harman
Arcuri	Cooper	Harper
Austria	Costa	Hastings (FL)
Baca	Costello	Hastings (WA)
Bachmann	Courtney	Heinrich
Bachus	Crenshaw	Heller
Baird	Crowley	Hensarling
Baldwin	Cuellar	Herger
Barrett (SC)	Culberson	Herseth Sandlin
Barrow	Cummings	Higgins
Bartlett	Dahlkemper	Hill
Barton (TX)	Davis (AL)	Himes
Bean	Davis (CA)	Hinchey
Becerra	Davis (IL)	Hinojosa
Berkley	Davis (KY)	Hirono
Berman	Davis (TN)	Hodes
Berry	Deal (GA)	Hoekstra
Biggert	DeFazio	Holden
Bilbray	DeGette	Holt
Bilirakis	Delahunt	Honda
Bishop (GA)	DeLauro	Hoyer
Bishop (NY)	Dent	Hunter
Bishop (UT)	Diaz-Balart, L.	Inglis
Blackburn	Diaz-Balart, M.	Inslee
Blumenauer	Dicks	Israel
Blunt	Dingell	Issa
Boccieri	Doggett	Jackson (IL)
Boehner	Donnelly (IN)	Jackson-Lee (TX)
Bonner	Doyle	
Bono Mack	Dreier	Jenkins
Boozman	Driehaus	Johnson (GA)
Boren	Duncan	Johnson (IL)
Boswell	Edwards (MD)	Johnson, E. B.
Boucher	Edwards (TX)	Johnson, Sam
Boustany	Ehlers	Jones
Boyd	Ellison	Jordan (OH)
Brady (PA)	Ellsworth	Kagen
Brady (TX)	Emerson	Kanjorski
Braley (IA)	Engel	Kaptur
Bright	Eshoo	Kennedy
Broun (GA)	Etheridge	Kildee
Brown, Corrine	Fallin	Kilpatrick (MI)
Brown-Waite, Ginny	Farr	Kilroy
	Fattah	Kind
Buchanan	Filner	King (IA)
Burgess	Flake	King (NY)
Burton (IN)	Fleming	Kingston
Butterfield	Forbes	Kirk
Buyer	Fortenberry	Kirkpatrick (AZ)
Calvert	Foster	Kissell
Camp	Foxx	Klein (FL)
Campbell	Frank (MA)	Kline (MN)
Cantor	Franks (AZ)	Kosmas
Cao	Frelinghuysen	Kratovil
Capito	Fudge	Kucinich
Capps	Gallegly	Lamborn
Capuano	Garamendi	Lance
Cardoza	Garrett (NJ)	Langevin
Carnahan	Gerlach	Larsen (WA)
Carney	Giffords	Larson (CT)
Carson (IN)	Gingrey (GA)	Latham
Cassidy	Gohmert	LaTourette
Castle	Gonzalez	Latta
Castor (FL)	Goodlatte	Lee (CA)
Chaffetz	Gordon (TN)	Lee (NY)
Chandler	Granger	Levin
Childers	Graves	Lewis (CA)
Chu	Grayson	Lewis (GA)
Clarke	Green, Al	Linder
Clay	Green, Gene	Lipinski
Cleaver	Griffith	LoBiondo
Loebsack	Pallone	Shea-Porter
Lofgren, Zoe	Pascrell	Sherman
Lowey	Pastor (AZ)	Shimkus
Lucas	Paul	Shuler
Luetkemeyer	Paulsen	Shuster
Luján	Payne	Simpson
Lummis	Pence	Sires
Lungren, Daniel E.	Perlmutter	Skelton
	Perriello	Slaughter
Lynch	Peters	Smith (NE)
Mack	Peterson	Smith (NJ)
Maffei	Petri	Smith (TX)
Maloney	Pingree (ME)	Smith (WA)
Manzullo	Pitts	Snyder
Marchant	Platts	Souder
Markey (CO)	Poe (TX)	Space
Markey (MA)	Polis (CO)	Speier
Marshall	Pomeroy	Spratt
Massa	Posey	Stark
Matheson	Price (GA)	Stearns
Matsui	Price (NC)	Stupak
McCarthy (CA)	Putnam	Sullivan
McCarthy (NY)	Quigley	Sutton
McClintock	Radanovich	Tanner
McCollum	Rahall	Taylor
McCotter	Rangel	Teague
McDermott	Rehberg	Terry
McGovern	Reichert	Thompson (CA)
McHenry	Reyes	Thompson (MS)
McIntyre	Richardson	Thompson (PA)
McKeon	Rodriguez	Thornberry
McMahon	Roe (TN)	Tiahrt
McMorris Rodgers	Rogers (AL)	Tiberi
	Rogers (KY)	Tierney
McNerney	Rogers (MI)	Titus
Meek (FL)	Rohrabacher	Tonko
Meeks (NY)	Rooney	Towns
Mica	Ros-Lehtinen	Tsongas
Michaud	Roskam	Turner
Miller (FL)	Ross	Upton
Miller (MI)	Roybal-Allard	Van Hollen
Miller (NC)	Royce	Velázquez
Miller, Gary	Ruppersberger	Visclosky
Minnick	Rush	Walden
Mitchell	Ryan (OH)	Walz
Mollohan	Ryan (WI)	Wamp
Moore (KS)	Salazar	Wasserman Schultz
Moran (KS)	Sánchez, Linda T.	
Moran (VA)		Waters
Murphy (CT)	Sanchez, Loretta	Watson
Murphy (NY)	Sarbanes	Watt
Murphy, Patrick	Scalise	Waxman
Murphy, Tim	Schakowsky	Weiner
Myrick	Schauer	Welch
Nadler (NY)	Schiff	Westmoreland
Napolitano	Schmidt	Wexler
Neal (MA)	Schock	Whitfield
Neugebauer	Schrader	Wilson (OH)
Nunes	Schwartz	Wilson (SC)
Nye	Scott (GA)	Wittman
Oberstar	Scott (VA)	Wolf
Obey	Sensenbrenner	Woolsey
Olson	Serrano	Wu
Olver	Sessions	Yarmuth
Ortiz	Sestak	Young (AK)
Owens	Shadegg	Young (FL)

NOT VOTING—8

Brown (SC)	Melancon	Murtha
Carter	Miller, George	Rothman (NJ)
McCaul	Moore (WI)	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1344

So (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

The title was amended so as to read: ''Concurrent resolution expressing the sense of Congress on the occasion of the 20th anniversary of historic events in Central and Eastern Europe, particularly the Velvet Revolution in Czechoslovakia, and reaffirming the bonds of friendship and cooperation between the United States and the Slovak Republic and the Czech Republic.''.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. ROTHMAN of New Jersey. Mr. Speaker, Wednesday, November 18, 2009, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 896: Passage of H. Con Res. 214. Had I been present, I would have voted ''yes.''

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 897: Motion on Ordering the Previous Question on the Rule for H.R. 3791. Had I been present, I would have voted ''yes.''

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 898: Passage of H. Res. 909. Had I been present, I would have voted ''yes.''

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 899: On agreeing to the Perlmutter (CO) Amendment. Had I been present, I would have voted ''yes.''

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 900: On agreeing to the Flake (AZ) Amendment. Had I been present, I would have voted ''no.''

Mr. Speaker, due to illness, and at the advice of my doctor, I was unable to vote on rollcall No. 901: On Passage of H.R. 3791. Had I been present, I would have voted ''yes.''

Mr. Speaker, on Thursday, November 19, 2009, due to my required participation in a classified national security meeting, I was unable to vote on rollcall No. 905: On Passage of H.R. 2781. Had I been present, I would have voted ''yes.''

Mr. Speaker, due to my required participation in a classified national security meeting, I was unable to vote on rollcall No. 906: On Passage of H. Con. Res. 212. Had I been present, I would have voted ''yes.''

MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 2009

Mr. WAXMAN. Mr. Speaker, pursuant to House Resolution 903, I call up the bill (H.R. 3961) to amend title XVIII of the Social Security Act to reform the Medicare SGR payment system for physicians, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. SALAZAR). Pursuant to House Resolution 903, the bill is considered read.

The text of the bill is as follows:

H.R. 3961

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 ''Medicare Physician Payment Reform Act of 2009''.

SEC. 2. MEDICARE SUSTAINABLE GROWTH RATE REFORM.

(a) TRANSITIONAL UPDATE FOR 2010.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(10) UPDATE FOR 2010.—The update to the single conversion factor established in paragraph (1)(C) for 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.''.

(b) REBASING SGR USING 2009; LIMITATION ON CUMULATIVE ADJUSTMENT PERIOD.—Section 1848(d)(4) of such Act (42 U.S.C. 1395w–4(d)(4)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (D)'' and inserting ''subparagraphs (D) and (G)''; and

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

''(G) REBASING USING 2009 FOR FUTURE UPDATE ADJUSTMENTS.—In determining the update adjustment factor under subparagraph (B) for 2011 and subsequent years—

''(i) the allowed expenditures for 2009 shall be equal to the amount of the actual expenditures for physicians' services during 2009; and

''(ii) the reference in subparagraph (B)(ii)(I) to 'April 1, 1996' shall be treated as a reference to 'January 1, 2009 (or, if later, the first day of the fifth year before the year involved)'.''.

(c) LIMITATION ON PHYSICIANS' SERVICES INCLUDED IN TARGET GROWTH RATE COMPUTATION TO SERVICES COVERED UNDER PHYSICIAN FEE SCHEDULE.—Effective for services furnished on or after January 1, 2009, section 1848(f)(4)(A) of such Act is amended by striking ''(such as clinical'' and all that follows through ''in a physician's office'' and inserting ''for which payment under this part is made under the fee schedule under this section, for services for practitioners described in section 1842(b)(18)(C) on a basis related to such fee schedule, or for services described in section 1861(p) (other than such services when furnished in the facility of a provider of services)''.

(d) ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR CATEGORIES OF SERVICES.—

(1) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

''(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2009, each of the following categories of physicians' services (as defined in paragraph (3)) shall be treated as a separate 'service category':

''(A) Evaluation and management services that are procedure codes (for services covered under this title) for—

''(i) services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under subsection (c)(5) as of December 31, 2009, and as subsequently modified by the Secretary); and

''(ii) preventive services (as defined in section 1861(iii)) for which payment is made under this section.

''(B) All other services not described in subparagraph (A).

Service categories established under this paragraph shall apply without regard to the specialty of the physician furnishing the service.''.

(2) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subparagraph (A)—

(i) by designating the sentence beginning ''The conversion factor'' as clause (i) with the heading ''APPLICATION OF SINGLE CONVERSION FACTOR.—'' and with appropriate indentation;

(ii) by striking ''The conversion factor'' and inserting ''Subject to clause (ii), the conversion factor''; and

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

''(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2011.—

''(I) IN GENERAL.—In applying clause (i) for years beginning with 2011, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

''(II) INITIAL CONVERSION FACTORS.—Such factors for 2011 shall be based upon the single conversion factor for the previous year multiplied by the update established under paragraph (11) for such category for 2011.

''(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (11) for the year involved.''; and

(B) in subparagraph (D), by striking ''other physicians' services'' and inserting ''for physicians' services described in the service category described in subsection (j)(5)(B)''.

(3) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)), as amended by subsection (a), is amended—

(A) in paragraph (4)(C)(iii), by striking ''The allowed'' and inserting ''Subject to paragraph (11)(B), the allowed''; and

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

''(11) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2011.—

''(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2011, the following rules apply:

''(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

''(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

''(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

''(II) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

''(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2010, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

''(i) FOR 2010.—For 2010:

''(I) TOTAL 2009 ACTUAL EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION FOR EACH SERVICE CATEGORY.—Compute total actual expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2009 for each service category.

''(II) INCREASE BY GROWTH RATE TO OBTAIN 2010 ALLOWED EXPENDITURES FOR SERVICE CATEGORY.—Compute allowed expenditures for the service category for 2010 by increasing the allowed expenditures for the service category for 2009 computed under subclause (I) by the target growth rate for such service category under subsection (f) for 2010.

''(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.''.

(4) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

(A) IN GENERAL.—Section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f)) is amended by adding at the end the following new paragraph:

''(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2010.—The target growth rate for a year beginning with 2010 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the target growth rate except that the factor described in paragraph (2)(C) for—

''(A) the service category described in subsection (j)(5)(A) shall be increased by 0.02; and

''(B) the service category described in subsection (j)(5)(B) shall be increased by 0.01.''.

(B) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(i) in subsection (d)—

(I) in paragraph (1)(E)(ii), by inserting ''or target'' after ''sustainable''; and

(II) in paragraph (4)(B)(ii)(II), by inserting ''or target'' after ''sustainable'';

(ii) in the heading of subsection (f), by inserting ''AND TARGET GROWTH RATE'' after ''SUSTAINABLE GROWTH RATE'';

(iii) in subsection (f)(1)—

(I) by striking ''and'' at the end of subparagraph (A);

(II) in subparagraph (B), by inserting ''before 2010'' after ''each succeeding year'' and by striking the period at the end and inserting ''; and''; and

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

''(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.''; and

(iv) in subsection (f)(2), in the matter before subparagraph (A), by inserting after ''beginning with 2000'' the following: ''and ending with 2009''.

(e) APPLICATION TO HEALTH CARE GROUP DEMONSTRATION PROGRAM AND SUCCESSOR ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.—In applying the target growth rate under subsections (d) and (f) of section 1848 of the Social Security Act to services furnished by a practitioner to beneficiaries who are attributable to a health care group under the demonstration program provided under section 1886A of such Act (or to an accountable care organization under a pilot program that is a succcessor to such demonstration program under a section of such Act), the Secretary of Health and Human Services shall develop, not later than January 1, 2012, for application beginning with 2012, a method that—

(1) allows each such group or organization to have its own expenditure targets and updates for such practitioners, with respect to beneficiaries who are attributable to that group or organization, that are consistent with the methodologies described in such subsection (f); and

(2) provides that the target growth rate applicable to other physicians shall not apply to such physicians to the extent that the physicians' services are furnished through the group or organization.

In applying paragraph (1), the Secretary of Health and Human Services may apply the difference in the update under such paragraph on a claim-by-claim or lump sum basis

and such a payment shall be taken into account under the demonstration or pilot program.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) and the gentleman from Texas (Mr. BARTON) each will control 30 minutes.

The Chair recognizes the gentleman from California.

Mr. WAXMAN. Mr. Speaker, I yield myself 3 minutes.

Today, we consider legislation that will maintain and strengthen Medicare for seniors and individuals with disabilities. A law passed in 1997 set a limit on payments to Medicare physicians. The idea was to save money, but the limit was set too low and required draconian cuts, forcing Congress to intervene with temporary fixes.

In 2004, the law required a 4.5 percent cut. In 2008, it was a 10.1 percent cut. This year, doctors face a 21 percent cut. These are unsustainable cuts that would bring about havoc in the Medicare program. Congress has responded by enacting temporary 1-year fixes. These temporary fixes only make the problem worse the next year. The result has been a cycle of ever increasing cuts followed by ever costlier fixes.

This is not a problem of mere budget or fiscal discipline; it is a kitchen table problem for America's seniors and for the physicians who are partners in the Medicare program. Medicare's ability to guarantee health care for seniors would be eliminated if these cuts went into effect.

We are rightly asking much of the health care providers in health reform. We are demanding they provide care more efficiently, that they improve the quality of care, and that they give taxpayers good value for their dollars. In return, we need to pay them fairly for their efforts and to be an honest partner. We have two basic choices. We can solve this problem permanently or we can enact another 1-year Band-Aid. This legislation says that we will finally enact a lasting reform.

The House recognized in our budget that honest accounting means facing this problem squarely and finding a way to address it. This legislation meets that call, replacing the sustainable growth rate for physicians, or SGR, which Congress enacted in 1997, with a more responsible and stable system for the future. We must be honest about this problem and address it responsibly and immediately. We can take that step today by passing this bill and combining it with statutory PAYGO, which will help restore fiscal discipline.

I urge Members to support adoption of this bill and reserve the balance of my time.

Mr. BARTON of Texas. I ask unanimous consent that of the 30 minutes that I control, the ranking member of the Ways and Means Committee, the gentleman from Michigan (Mr. CAMP), control 15 of those minutes.

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

There was no objection.

Mr. BARTON of Texas. I would yield myself 1 minute.

Mr. Speaker, the only fix that's in this bill before us is ''the fix is in.'' This is nothing more than a repayment to the American Medical Association for endorsing the larger health care bill that was on the floor several weeks ago. There is not one dime of pay-for in this bill. It is a wave the magic wand, erase the accumulated deficit of the last 10 years or so in the SGR formula, and let's kick the can on down the road.

The bill is so narrowly construed that we couldn't offer in the motion to recommit a real pay-for because this bill doesn't have a pay-for. This is nothing more than a political payoff to the American Medical Association. Republicans support really fixing the SGR system, but we think it ought to be done all at the same time. So we would hope that we would vote against this sham today.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I'm pleased at this point to yield 1 minute to the distinguished majority leader to speak on the legislation, the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. I thank the distinguished chairman for yielding, and I rise in strong support of this legislation. I want to say to my friend who has just spoken, the ranking member of the committee who chaired the committee, who said they wanted to pay for things, what this bill does is put statutory PAYGO into law. He's right. But what he didn't say to you is when their side controlled the Presidency, the House, and the Senate, they jettisoned paying for things. They did away with statutory PAYGO, they did away with PAYGO generally, and what happened? We went from substantial surpluses under the Clinton administration to substantial deficits under the Bush administration.

Now we were told those substantial deficits and deficits that were being created would create economic growth in our country. In point of fact, however, after 8 years of that economic policy where they jettisoned PAYGO, a PAYGO which provided $5.6 trillion of surplus available in March 2001, according to President Bush; but they abandoned PAYGO, which is in this bill.

This is not a question of payoff to anybody. This was in the President's budget when he sent it down here earlier this year. It was in our budget that passed the House and the Senate. We said we were going to do this. Why? Because it's the right thing to do. Today, we have the chance to vote for health care our seniors can count on and a fiscal future for all Americans that they can have faith in.

Very frankly, my friend also said, We on the Republican side want to fix this. My question is simply: Why didn't you? Why do we still have this issue that confronts us year after year after year because we didn't have the courage to face it? I'm going to talk about the deficit, because this adds to the deficit. I will lament that, but there is not an option, as you added to the deficit every time you fixed it one year at a time. Doctors couldn't rely on it. More importantly, seniors couldn't rely on the fact that their doctors wouldn't have a big cut and push them out. I'm going to talk about that as well. We can do it by stopping a massive Medicare payment cut and by committing future policies to the tested principle of pay-as-you-go.

Now my friends on the other side of the aisle don't like pay-as-you-go because it constrained them in cutting revenues over a trillion dollars, which is one of the reasons we have such a large deficit, because they didn't pay for what they bought. Interestingly enough, my friends, they bought at a rate twice the growth in spending that occurred during the 1990s, in the 2000s, which was about 3½ percent per year. It was 7 percent a year when my friends on the other side of the aisle controlled all of the levers of power. So they decreased revenue and increased spending, and we had large deficits and the biggest recession we have faced since the 1930s were inherited by this administration and, frankly, by this Congress.

Now going back to the pay-as-you-go. First, the Medicare payment rate cut, if we do nothing, payments to doctors treating Medicare patients will drop by 21 percent in the new year with more cuts in the years to come. If we allow that to take place, many seniors will find their doctors no longer available to treat them.

So this is not only about compensating doctors for the services that are vitally important and we want them to give, but it is also protecting seniors' access to doctors. That will mean less access to health care, longer waiting lists, and serious conditions going untreated and.

In sum, if we do not act on this bill, it will mean sicker seniors. That's why it's essential that we stop these cuts before they're allowed to take effect. The cuts, of course, will occur on January 1 of this year, approximately 1 month from today.

It is important to remember that this bill would simply prevent cuts, not increase payments to doctors. But it is true that ensuring our seniors' access to their doctors will add to our deficit, just as extending any of the Bush tax cuts that are set to expire next year would do. Because seniors' health is at stake in this bill, I believe that stopping these payment cuts is worth the cost.

It's also worth pointing out that this bill represents a new honesty in budgeting. As far as Democrats are concerned, the days of pretending that the costs of the ''doctor fix'' will be made up by even deeper cuts next year are over. That, of course, is a policy we followed in the first 8 years of this decade. We pretended that somehow we'd

fix it later, and we never did. Indeed, most of the costs associated with this bill are the result of stopping the gimmicks that were used for years and cleaning up the mess created by those gimmicks. The first step to getting out of debt is being honest about the debt we're in. It is too deep, it is dangerous, and we need to address it.

So let's be honest. Our country is in a deep fiscal hole for reasons that go far beyond Medicare payments. In fact, there's no one reason for our record national debt. It's bipartisan in nature, not exclusively Republican or Democrat.

The causes include the previous administration's debt financed tax cuts, which I've spoken of, for America's essentially wealthier citizens who got most of the tax cuts; the cost of two wars, which we did not pay for; our escalating entitlements programs, which all of us have supported; the recession that we have confronted and that started in the seventh year of the previous administration's term; and the deficit spending—and we need to clean up that economic mess; spending that economists tell us is necessary to stimulate demand and recession.

In other words, we needed to spend the money to preclude a depression, not just a deep recession that we're in, and almost every economist, including Marty Feldstein, said that that was necessary.

A recent New York Times analysis tells us that 90 percent of our deficit has been brought about by the policies of the previous administration and the extension of its policies and the economic crisis that it left behind.

□ 1400

No one step will get us out of our fiscal hole, but the most important immediate step we can take is to commit ourselves to the principle that in new policies of our country, we will pay for what we buy. That is the principle of pay-as-you-go, or PAYGO, which was in place in the 1990s as we went from deep debt into surplus and that $5.6 trillion surplus that President Bush inherited in 2001. In the 1990s, President Clinton used it to turn huge deficits into a record surplus, and when President Bush abandoned PAYGO, and my friends on the other side of the aisle abandoned PAYGO, record deficits returned.

When Democrats took back the House majority in 2006, we demonstrated our commitment to fiscal responsibility by making PAYGO a part of the House rules. It's sometimes been difficult. And now with the support from President Obama and both Chambers of Congress, we have a real chance to give PAYGO the force of law by passing this bill. Under PAYGO, Congress will be forced to offset all new policies reducing revenues or expanding entitlements, so that they add nothing to our deficit.

In essence, we will be forced to make the hard budgeting choices that are so tempting to avoid. We are avoiding them today. We ought to admit that very honestly. Why are we doing it? Because as a practical matter, in the deep recession that we're in, we cannot pay for it without depressing the economy further.

That is not an acceptable alternative. If we want to cut taxes, we'll have to explain which programs will suffer cuts. If we want to expand entitlements, we'll have to spell out how we are going to pay for it. And no matter which party is in power, we'll be forced to distinguish wasteful spending and subsidies from the long-term priorities that really matter to our country.

Some have explained that statutory PAYGO would not apply to extensions of some existing policies that have bipartisan support, one of which is the one we're talking about today. Policies on the alternative minimum tax, which we've already done. And by the way, I am one of those—wasn't in the majority—who voted against extending the alternative minimum tax if we did not pay for it. In addition to that, Medicare doctor payments, which we're talking about today, and the estate and middle-income tax cuts passed in 2001 and 2003.

I sympathize with their concerns. They are not specious concerns. I have said repeatedly that I would fight to pay for all of these policies. Hear me, if the Senate sends this back paid for, I will support it. I challenge all of you on that side of the aisle and all of you on this side of the aisle to do the same. That stands in contrast, frankly, to the first 8 years of this decade, when repeatedly it was stated that they do not believe that extensions of tax cuts need to be paid for.

Unfortunately, it's a political reality that the votes to pay for extensions of the Bush policies are most likely not there. A PAYGO law that ignored that fact would be waived for those policies and then again and again. I prefer a law that we can enforce consistently. And very frankly, that is supported by some of the most consistent voters for fiscal responsibility on this floor.

Mr. Speaker, in our country's economic meltdown last year, we all saw the damage that deep debt can do. It's time for our Federal Government to learn that lesson and act on it. If we fail to act, liberal and conservative, Democratic and Republican, priorities will suffer alike. We can still prevent that outcome, ladies and gentlemen of this House. We cannot get back to fiscal health in one afternoon's vote, and we will not, perhaps not in this President's term or the next, but we must start. We must take a step toward that end.

This bill does that. It supports not only ensuring our seniors access to quality medical services but also ensures that we, again, adopt the policy that brought us $5.6 trillion in surplus.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Parliamentary inquiry.

The SPEAKER pro tempore (Mr. SALAZAR). The gentleman will state his parliamentary inquiry.

Mr. BARTON of Texas. Under the rules that we operate where we alternate back and forth, is it allowable for myself to make a rebuttal and then recognize the gentleman from Indiana? Or do I have to do one or the other?

The SPEAKER pro tempore. The Chair may exercise his discretion in recognition in that fashion.

Mr. BARTON of Texas. I am going to recognize myself for 1 minute to comment on my friend from Maryland's comments. Then hopefully the Chair will let me recognize the gentleman from Indiana (Mr. PENCE) for 3 minutes.

Mr. Speaker, first of all, under Republican control, every bill that we brought to the floor, except one bill, was paid for either in that bill or in our budget resolution. There was one exception to that where we did not pay for it. So that is answer number one. Answer number two, this is not paid for. Under a bill that my friends in the majority passed in July, they say we're going to start pay-for, but it doesn't count for the doctors fix, it doesn't count for the alternative minimum tax, and it doesn't count for the estate tax.

But once we do all that without paying for it, then the pay for will kick in. So in that sense, my good friend from Maryland is accurate. But in the sense of this bill, he is totally inaccurate. This bill is not paid for.

Now, Mr. Speaker, if I am allowed to, I yield 3 minutes to my good friend from Indiana (Mr. PENCE).

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

Mr. PENCE. I thank the gentleman for yielding and for his leadership on this critical issue.

Mr. Speaker, I rise in opposition to H.R. 3961, which, rightly understood, is just the latest deficit-spending bill championed by my Democrat colleagues here on Capitol Hill. It is, in a very real sense, an addendum to the government takeover of health care that was rammed through this House just 2 short weeks ago with a pricetag in excess of $1.3 trillion.

You know, the President of the United States just said in China, If we keep adding to the debt even in the midst of this recovery, people could lose confidence in the U.S. economy. Maybe it would help if the President said that in America instead of China. Then maybe his party would get the message. Two days ago, we learned the national debt just pushed past $12 trillion. That means every man, woman and child in this country bears the burden of more than $38,000 in Federal Government debt.

In October alone, the deficit reached $176.4 billion and now comes one more deficit-spending bill to facilitate passage of a government takeover of health care. Under the guise of helping

doctors and seniors, this will cost the taxpayers of future generations $200 billion, and it all goes straight to deficits and debt. One analysis by the Heritage Foundation estimates the cost of this bill over 75 years at nearly $2 trillion, and Medicare premiums are estimated to increase by some $50 billion.

It seems there is no level of spending and debt that Washington Democrats aren't willing to pile on struggling families and future generations. We're here today considering this latest deficit-spending bill because Democrat leaders refuse to address health care reform in a fiscally responsible way. It is worth noting that this so-called doctors fix was a part of earlier versions of health care reform, but to perpetrate the fiction that their government takeover of health care was passed in a fiscally responsible way, we are doing this addendum to the Pelosi health care bill.

The truth is, the spending policies of this Congress and this administration are a fiscal timebomb being placed on the doorstep of our children's future. We have a responsibility to put our fiscal house in order. But sadly, there are those who would rather pursue an ambitious liberal agenda, no matter what the cost, at the possible expense of our children's posterity and prosperity.

There is a Republican plan which we support. It will fix the problem that we are trying to address over the next 4 years. It will pay for the bill. It will lay the groundwork for meaningful health care reform by ending an era of defensive medicine. I just hasten to repeat, this is just one more deficit-spending bill in an era when the American people are bone weary of runaway Federal spending.

Frankly, when Republicans were in control, we did our share of deficit spending, and the American people showed us the door. What we have here in Washington, D.C., as evidence today, is runaway Federal spending on steroids. You know, there is a rule back in Indiana, where I grew up. When you are in a hole, stop digging. Today we're going to dig the hole of the deficit even deeper, and the American people deserve better.

I urge my colleagues to oppose this measure and support the Republican plan.

Mr. WAXMAN. Mr. Speaker, I yield myself 1 minute.

I do want the American people to understand the Republican position, because this is what they would do to Medicare. If we didn't have health reform, we still have to deal with the problem we are having with Medicare, where millions of seniors are relying on that program. And if they produce a 20 percent cut in physician fees, the people in Medicare will not be able to get access to doctors. That means that if we don't deal with the whole health care system and hold down the costs, and we don't do health reform, Medicare will face deeper and deeper cuts, and the Republicans are giving a clear indication of that's exactly what they would do.

Mr. Speaker, I yield 2 minutes to our champion on health reform, the gentleman from Michigan (Mr. DINGELL).

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

Mr. DINGELL. Mr. Speaker, I rise as a proud supporter of H.R. 3961, and I urge my colleagues to join me in supporting it. H.R. 3961 fulfills a promise to our doctors that they're going to be appropriately paid for their services, and it assures that Medicare will continue to be available to provide services for our seniors.

In my home State of Michigan, this bill will prevent a loss of $610 million next year for the care of elderly and disabled patients. On average, H.R. 3961 will prevent cuts of $23,000 to each Michigan physician next year. Our Republican colleagues would have us think that this is a gimmick. What this legislation does is do away with a gimmick. I would remind my colleagues that H.R. 3961 solves a problem that's plagued the Congress since 2002 and actually ends a budget gimmick that artificially reduces the deficit by assuming that physician payments will be cut by 40 percent over the next several years, even though the Congress consistently intervenes to prevent those cuts from occurring.

Due to our failure to fix this problem permanently, the price tag has grown each year and will continue to do so. In 2005, the cost of fixing the problem was $48 billion. Today, just 4 years later, the cost has skyrocketed to $210 billion. We can no longer kick the can down the road. That is fiscally responsible. So today the choice is clear: Either we're going to be serious about protecting our seniors and protecting Medicare by providing a fiscally responsible, permanent fix to our perennial problems or we're going to play political games.

I urge my colleagues to choose the former. Vote in favor of H.R. 3961. Vote for fair treatment for our doctors. Vote to make Medicare payments available for doctors and for seniors. And make sure by so voting that you will have a situation where our doctors will be available to provide service for our senior citizens.

Mr. BARTON of Texas. I yield 1 minute to the gentleman from Kentucky (Mr. WHITFIELD), a member of the Health Subcommittee.

Mr. WHITFIELD. There is certainly enough blame to go around for both parties in the U.S. Congress as far as the debt is concerned. I have heard a lot of discussion today about being concerned about senior citizens having access to Medicare, and yet the health care bill that passed this House takes $500 billion out of Medicare. We've heard a lot about the PAYGO rules. In the 110th Congress, the PAYGO rules were waived 12 times for almost $500 billion.

As I have said, both parties have a lot of blame for the debt that we're in, and the American people want us to be responsible. We have a $12 trillion debt today. Within 10 years, it's supposed to be $23 trillion. At some point, we have to meet our obligation, meet our responsibility and try to pay for some of these programs. All of us support the purpose of this legislation, but there must be a way that we can do it and have it paid for. So for that reason, I would have great difficulty voting for this legislation without it being clearly paid for.

□ 1415

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE), the chairman of the Health Subcommittee of the Energy and Commerce Committee.

Mr. PALLONE. Mr. Speaker, I respect my Republican colleagues, but I think they are suffering from a severe case of amnesia when I listen to what they are saying on the other side. It was they who contributed to this problem in the first place. It was they who stuck their heads in the sand year after year and refused to enact any kind of meaningful reform. They talk about pay-for. They never paid for anything. They just kicked the can down the road and said, Okay, we won't have a cut this year but we will have a larger cut next year. If this continues, we will have a 40 percent cut in the reimbursement rate in the next 2 years. So there is no pay-for on their side. There never has been. It is just a budget gimmick.

Now this year, we have a permanent solution to the problem, and we are saying enough is enough with the threat of severe payment cuts that will drive physicians from Medicare and put beneficiaries' access to doctors in jeopardy.

Mr. Speaker, this legislation is an important element of our overall effort to improve Medicare for seniors. We have done a lot in health care reform. Two weeks ago we passed comprehensive health reform that made critical investments in Medicare. Amongst those, we closed the doughnut hole, thereby making prescription drugs more affordable. We improve access to preventative, primary, and coordinated care, and we increased financial assistance so that low-income seniors can better afford their monthly premiums.

We are helping seniors with this bill today by making them have a choice of physicians and quality physicians. We are helping them with the doughnut hole. We are helping them with everything with this larger health care reform.

I would just ask my Republican colleagues, don't kick the can down the road again. Don't give us all these budget gimmicks again. This is a real solution to the problem. Join us. Make this a bipartisan effort today, and let's pass this comprehensive reform.

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

I would ask the distinguished chairman of the Health Subcommittee:

Where is the fix? There is no fix in this bill.

They split one formula into two, but there is no reform in it. It is not based on medical expenses. It is not based on anything. There is no automatic reduction. It simply erases the current deficit in the account, has two formulas instead of one, and then 4 or 5 years from now, we will kick the can down the road again.

If there really is a fix, let's have somebody on the majority side explain it. You can't explain it because it is not there.

I yield 1 minute to a member of the Health Subcommittee, the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY of Georgia. Mr. Speaker, I rise today as a medical practitioner, one of 13 on the Republican side, in strong opposition to H.R. 3961. H.R. 3961 does not fix our physician reimbursement problem. It simply replaces one system of cuts with another. The bill, however, would add more than $200 billion to the Federal deficit at a time when our patients are struggling to find or keep the jobs they have today.

Mr. Speaker, if the details of this bill are not bad enough, the political reality is even worse. The Senate tried a similar sham of a bill last month, and 13 Senate Democrats sided with every Republican to reject it; however, House Democrats don't seem to be listening.

The time for empty promises has long since passed. We as a Nation can no longer afford to walk blindly down this path of fiscal irresponsibility. As mentioned, with $12 trillion in debt, I, for one, refuse to add another quarter trillion dollars to that debt.

I urge my colleagues to vote against this empty promise.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 2 minutes to the chairman of the House Budget Committee, the gentleman from South Carolina (Mr. SPRATT).

Mr. SPRATT. Mr. Speaker, I was here at the creation of the sustainable growth rate formula. It was part of the balanced budget agreement of 1997. I am here today to say that the SGR has not worked.

Here is the problem MedPAC presented to us in 1997:

In year 2, when we sought to curb or cut Medicare rates, volume increases in year 2 tended to make up the difference due to reduced rates.

In year 3, therefore, an automatic adjustment factor or formula was needed to target and recoup excess payments. Sound complicated? Well, that is a simple version. Suffice it to say, the SGR has proven to be so complex, so blunt an instrument, and so draconian that it has barely been used.

For example, in 2008, we reversed a 10.6 percent decrease in physicians' rates and replaced it with a 1.1 percent increase. In 2010, the SGR dictates a 21 percent cut in physicians' payment rates. You and I know that is not going to happen.

By assuming that the SGR will be applied, when we know it has not been applied, and is unlikely to be followed in the future, Medicare spending is substantially understated. CBO says that the rewrite of SGR now before us will result in a net spending increase of $210 billion over 10 years. The CBO has to assume that the SGR will be strictly applied in each of those 10 years. CBO is bound by its rule of projecting the budget; we are not. We know that the SGR is unlikely to be applied, and so the right step, straightforward step, is to pass this bill and change the SGR, not by wiping it out, but by replacing it with an updated formula that is realistic and likely to be used.

The bill before us reflects two agreements that are in the budget resolution for this year. One is to strengthen fiscal responsibility by enacting a statutory pay-as-you-go rule. The other is to institute realistic budgeting by changing this flawed formula called the sustainable growth rate factor.

The budget resolution allows the budget effects of changing the SGR to be calculated against a realistic baseline, one that reflects current policy. This means the baseline assuming the payment rates in effect for physicians in 2009 will stay in effect through 2019.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. WAXMAN. I yield the gentleman an additional 1 minute.

Mr. SPRATT. This baseline assumption represents a realistic benchmark against which to measure the fiscal effects of legislation reforming Medicare's physician payment system. Without a realistic baseline, we will revisit this issue every year, as we have in the past, by passing short-term fixes that do nothing to address the long-term problems. Without the reforms in this legislation, the budget will continue to understate the real cost to the Treasury of Medicare payments.

So now is the time to adjust the SGR. The bill before us is a constructive solution. After 6 years of short-term fixes that did little to address the underlying causes of excess cost growth, we now have the opportunity to vote for a substantive bill. This bill does not allow for uncontrolled spending growth. It provides realistic spending targets that are fair, frugal, and holds physicians accountable.

This bill does address two of the most important challenges in health care: better support for primary care and better coordination of care. It does so by, among other things, providing an extra growth allowance for primary care services. The bill also provides incentives for the creation of accountable care organizations which encourage providers to improve quality and control costs by coordination among all providers serving a patient. This is the type of structural reform we need.

This is a good bill. I urge its support.

Mr. BARTON of Texas. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. GOHMERT).

Mr. GOHMERT. Mr. Speaker, you know, we are still hearing blame for Bush and blame for the Republican-controlled House from the Democrats. The Speaker of the House has been a Democrat for right at 3 years now. It is time to take responsibility. We keep hearing that word ''responsibility.'' This is a good time to take it.

Now, we heard about the PAYGO rules that were passed, and now it is going to be PAYGO. And I tell you what, it didn't apply. It wasn't used like it should have been. And then in July, some of my Democratic colleagues convinced me that, you know what, we are really, really, really serious this time about PAYGO. Just vote with us. We'll show you how serious we are. I was one of 24 Republicans that voted for the PAYGO bill. But then we find out, no, no, no, this time we are really, really, really, really serious about PAYGO if you'll just pass it again this time. Come on now.

The docs do need a fix, but we don't need lectures on this side about the seniors not needing cuts when the bill that is before the House, that passed the House, is going to cut Medicare $400 billion or so.

Let's fix the problem for the doctors permanently. They deserve that. Let's not stockpile more debt on our grandchildren irresponsibly. We can do it, but this is not a permanent fix as some have said; otherwise, it wouldn't have a year limitation on it. Let's do the right thing by seniors, by doctors and our grandchildren and vote this one down and really, really, really get serious about PAYGO.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 1 minute to the gentleman from New York (Mr. ENGEL), an important member of our committee.

Mr. ENGEL. I thank my friend for yielding to me.

You know, it is always amazing to me when my Republican friends lecture us about debt or fiscal responsibility when they were in the majority here for 12 years, and for six of those years they did nothing to stop the debt. They did nothing to balance the budget. And now we get lectured.

But I rise in strong support of the Medicare Physician Payment Reform Act, a key component of comprehensive health insurance reform. It is providing our seniors with stable access to their trusted health care providers.

Each year, due to a flawed Medicare payment policy, our physicians face mounting cuts which threaten their ability to care for the patients that depend on them, and at the 11th hour, we have done a short-term patch each and ever year. It is not a good way to run Medicare. This year we are doing it differently. We are ending that. Not only will we eliminate the scheduled 21 percent reduction, but we will replace the flawed sustainable growth rate formula which is responsible for these annual cuts with a more rational payment system.

By doing so, we will preserve access to care and provide physicians with the financial stability they need. The 11th hour is not a way to do it. Our physicians face these mounting cuts, threatening their ability. This is the best way to go about it.

I urge my colleagues to support the bill.

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

Since my friends on the Democrat side won't explain their procedure, their bill, I am going to try and do it, and if I am wrong, I am sure that they will correct me.

Current law, we have one SGR formula. It is based on GDP and inflation. It is not based on any kind of medical index. Whatever that is perceived to be each year, that is the amount of increase we can pay our physicians. All physicians get the same increase.

Under this bill, they say if you are a primary care doctor, you get the formula plus 2 percent. If you are a specialist, you get the formula plus 1 percent, but they don't change the formula. The formula is the same as it is under the current law, and they don't change the enforcement mechanism. The enforcement mechanism is the same as it is under current law; i.e., Congress has to vote to either accept the cuts or to not accept the cuts and provide a temporary fix. As I understand it, that is their fix. Now, if I am wrong in that, I want my friend Mr. WAXMAN or Mr. PALLONE or Mr. RANGEL or Mr. STARK to tell me how I am wrong.

Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 1 minute to the gentleman from Maryland (Mr. SARBANES), a member of the Energy and Commerce Committee and the Health Subcommittee.

Mr. SARBANES. Mr. Speaker, I thank the chairman for yielding me this time.

I just want to say to all of the seniors in my district and seniors across the country who have expressed anxiety over the last few months, and really for longer than that, that this physician payment cut would go into effect, that we heard what you were saying and we will take action today. Many of you are concerned because your doctors have been telling you that this payment cut is coming. Frankly, these physicians don't feel they are treated as professionals when we jerk them around at the end of a string every year. That is why we want to permanently fix this problem.

We make sure that physicians are reimbursed properly and fairly so they will have an incentive to remain in the Medicare program, and that way there will be a good, robust supply of physicians to serve the Medicare population. That is why we are doing this today.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Nebraska (Mr. TERRY), a member of the Energy and Commerce Committee.

Mr. TERRY. Mr. Speaker, I don't think there is really any debate whether on one side or the other. This side supports a permanent fix to SGR. The argument here today, and the dispute here today is that we have, what, $270 billion that is not being paid for or offset properly.

If we are going to be about fiscal responsibility and protecting the future of our kids by not piling on deficit and then debt onto them, this is where the buck stops, literally, here today is that we need to pay for this, not just put it to the deficit and the debt.

But I keep hearing the talk about seniors here. We want to make sure that they have complete access to their health care, but I have to point out the irony that at 11, 11:30 a week ago last Saturday, they took a vote to cut half a trillion dollars out of Medicare and move it to a new plan away from seniors. I think we need to talk about the irony here and who is really standing up for the seniors.

□ 1430

Mr. WAXMAN. Mr. Speaker, I yield myself 1 minute.

I want to point out to my colleagues while we're blaming each other on a partisan basis that the reason we got into this situation is in 1997 with a Republican Congress and a Democratic President, there was a so-called balanced budget proposal adopted, and the way it was funded for tax cuts was to make future cuts in Medicare, especially in the physician payment side. We are paying the price of that poorly thought-through approach, which was the reason I voted against that bill in 1997.

The gentleman from Texas made some points about the situation we're in. What he did not point out is that this bill is part of a comprehensive improvement in our health care system. It would reward primary care. It would provide for accountability care organizations, which would be a better delivery mechanism. This ought to be looked at in a more comprehensive way.

That's why I'm pleased to support this bill today and the health care reform bill that the House passed a week or so ago, and we hope to complete our actions with the Senate later this year.

Mr. Speaker, I yield the balance of my time to the Ways and Means Committee chairman, the gentleman from New York (Mr. RANGEL), and I ask unanimous consent that he be allowed to control that time.

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

There was no objection.

GENERAL LEAVE

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on H.R. 3961.

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

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished minority leader from the great State of Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

I tell my colleagues that during this debate over health care that's gone on for most of this year, Republicans have been listening to the American people; and what the American people want is they want to lower the cost of health care so that it's more affordable for more Americans.

When it comes to this issue of fixing the doctors' payment reimbursement system in Medicare, there's no dispute on either side of the aisle about the need to address it. Republicans addressed it when we were in the majority; and when we did, we made sure that there were offsets in spending elsewhere or some other types of revenue to make sure that it was paid for and not added to the budget deficit.

The issue here is twofold. One is that the proposal will not fix the problems that docs have in terms of their reimbursements down the road. It's a flawed formula that is not eliminated in this proposal. Secondly, it's going to add some $250 billion worth of debt put onto the backs of our kids and grandkids.

Now, I have listened to Democrats. The President, the President's Chief of Staff, Democrat leaders over the last couple of weeks talk about the fact that we need to do something about the budget deficit. Well, give me a break. Why don't we start right now. Right now and say that we're not going to do this, that we're not going to pass this bill that has no chance of becoming law. The Senate has already rejected it.

Why don't we just work together to come up with something that we can afford to cover the next 2, 3, 4 years so the doctors will have some idea of what their payments will be from us and get serious about working together for a long-term fix that doesn't put this responsibility on the backs of our kids and our grandkids.

That's the real issue here, the fact that there is no pay-for here. There is no offsetting other types of spending. There are no increases in revenue somewhere to cover this. It's just going to be dumped onto the backs of our kids and grandkids.

The American people want us to relearn fiscal responsibility. My colleagues on my side of the aisle over the course of this year have stood up, I believe, for fiscal responsibility. And if we're going to get our economy going again, we'd better get our fiscal house in order as well.

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

Mr. Speaker, I rise in support of H.R. 3961, and I feel so proud that the Ways and Means Committee was able to make a contribution with the other two committees, Education and Labor as well as Energy and Commerce, to

bring the John Dingell medical reform bill before this House and before this country.

What it does, really, is a new way to provide health care that is perfected in such a way that the patients are able to get medical care before they become patients, have preventative care, to provide for new doctors to be able to be made, and to get rid of a flawed physician payment system that, indeed, will strengthen the Medicare program.

At the end of the day when you hear the opposition, most all of their comments are going to be negative and saying ''no.'' Even when we make our case as to why we should fulfill our obligation to the doctors, they will make some decisions here, procedure decisions, which my friend Mr. BARTON gets fed up with, but I assume he will be leading the race and saying that there should be a way to resubmit this bill to the committees to do something all over again.

If that is the case, I am certain that the American Medical Association as well as the older people and those people who need these doctors will not have to fear anything because their answer to this will be rejected, and once again we will be able to fulfill the promise that we made with the health bill by making certain they have doctors in order to support it.

At this time, Mr. Speaker, I yield the balance of my time to Chairman PETE STARK, who has made such an important contribution over the years to reform our health system, and I ask unanimous consent that he be allowed to control that time.

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

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, could I inquire as to how much time I still control, please.

The SPEAKER pro tempore. The gentleman has 3 minutes remaining.

Mr. BARTON of Texas. I want to yield 1 of those 3 minutes to the gentlewoman from Nashville, Tennessee, a member of the Energy and Commerce Committee, Congresswoman MARSHA BLACKBURN.

Mrs. BLACKBURN. I thank the gentleman from Texas for yielding.

Mr. Speaker, I would remind my colleagues here in the House that we know something is wrong with the piece of legislation when you have major media outlets talking about how off-track this is, and you also know something's wrong with it when you have our colleagues in the Senate who take up a bill, this bill, and they can't get to 50 votes in the Senate for the companion legislation. So it is with a real sense of regret that I think many of us look at this.

Does the standard growth rate, SGR, need to be fixed? Absolutely. And there is agreement on that. It is an issue out of fairness to our Nation's physicians, the providers of health care. It is an issue of fairness to our Nation's seniors.

Mr. Speaker, I think it has been really something that has been of concern to us as we have watched some of our colleagues in this House treat Medicare as a slush fund rather than recognizing that it is a trust fund and it's there for those seniors. We can do better. Our seniors and our physicians deserve better.

Mr. STARK. Mr. Speaker, I yield myself 3 minutes.

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

Mr. STARK. Mr. Speaker, I would like to place in the RECORD a letter from the American Medical Association and a list of over 150 supporters of H.R. 3961, among which are the American College of Obstetricians and Gynecologists, the Iowa Medical Society, the Texas Medical Society, all of whom I think place Hippocrates ahead of Sarah Palin in terms of their assessment of what should be done.

I would further begin in addressing my dear friend from Texas in some of his inquiry earlier by quoting from the ranking member of the Health Subcommittee on the Ways and Means Committee back last July when he said he believed Members on both sides of the aisle agree that there is a need for a long-term fix for the Medicare physician payment. All 15 members, Republican members, of the Ways and Means Committee voted basically for the fix we're talking about today.

Let me make no mistake about blame and where we are. It may come as a surprise to our side of the aisle we make mistakes. In 1997 we made a mistake in setting the formula by which we would automatically limit the increase that doctors get paid. Well, we're here today trying to correct that mistake.

You've said so, correctly, that it's the same formula plus 2 percent for primary care, 1 percent for other physicians, some other plans to help encourage primary care doctors to come into practice. Hopefully, we've done it right, and recognizing if we don't correct it, we're talking about hundreds of billions of dollars by postponing. So we have postponed, whether on either side of the aisle, we have postponed correcting a mistake that we should have done earlier.

That's where we are today. No place else. And I hope that we can get the continued support to do that. I hope we don't have to come back and keep addressing it. I see not correcting it increases the amount we will have to pay in the future.

So there is plenty of blame, as the gentleman suggested, to go around. We could have fought harder to correct it earlier. We didn't and that's where we are today.

Literally every major medical society in the country has suggested that we do it this way, and I urge my colleagues to join with me, hopefully with my 15 colleagues on the Ways and Means Committee who haven't changed their mind, and support H.R. 3961 today so we can put this behind us. Then we can go on and have some really spirited debate about whether they do a better job in Texas or California of reforming medical care. That will be more fun.

But today let's fix this. Pass H.R. 3961, go home and have a wonderful Thanksgiving holiday, and come back to work on health care reform.

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, November 19, 2009.

Hon. DAVE CAMP,
Ranking Member, House of Representatives, Washington, DC.

DEAR REPRESENTATIVE CAMP: Thank you for your letter of November 18, 2009, regarding the pending Congressional consideration of H.R. 3961, the Medicare Physician Payment Reform Act of 2009. We appreciate your agreement that having physicians face annual cuts due to the flawed SGR is unacceptable and your support for the intent of the legislation. As you know, it is the same policy supported by every Republican on the Ways and Means Committee during the mark-up of H.R. 3200.

We are disappointed, however, that you and your colleagues do not support the bill. As you know, the SGR was put into place by the Balanced Budget Act of 1997, which originated in your committee. At that time, the AMA wrote numerous letters to Speaker Gingrich and your committee leadership warning that limiting growth in physician services to GDP would inevitably lead to sharp cuts in physician reimbursement and a crisis in access to care for our nation's seniors. Previously we had supported legislation that would have allowed growth at a rate above GDP.

As predicted, the SGR did result in a 4.8% cut to physicians for the year 2002. Congress declined to intervene and that cut went into effect. In subsequent years, Congress did step in to prevent additional cuts from occurring. The Consolidated Appropriations Resolution of 2003, the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007, and the Medicare Improvement for Patients and Providers Act of 2008 each provided temporary relief for seniors and their physicians from pending cuts.

What these bills did not do, however, was make any progress toward fixing the problem. Instead, Congress fell into a comfortable rhythm of kicking the can down the road and putting off real reform to some unspecified point in the future. In 2005, physicians faced a cut of 3.3% which was averted by the MMA. At that time, the Congressional Budget Office reported that the cost of just a ten-year freeze in physician rates was $48.6 billion. Just four years later, the pending cut stood at 21.5% and the cost of a ten year freeze stood at $285 billion. The AMA believes that this cycle must come to an end. Anything short of permanent reform will not be supported by the AMA. Every year that Congress ''pays-for'' a temporary solution, the cost of permanent reform climbs higher still. These are obligations to our seniors which the Medicare program has already made. To pretend that they will not be incurred is unrealistic. To continue to grow the size of the problem is irresponsible.

As for the implication that the recent action by the Administration to remove drugs from the SGR are ''budget gimmicks to hide the true deficit impact,'' we are reminded of a letter you signed on May 21, 2004, to the Bush administration calling the policy of including drugs in the formula ''our greatest concern'' regarding the magnitude of the

SGR problem. That letter was also signed by other members of your committee. On June 16, 2004, Representative Cantor sent a similar letter with Representative Pryce urging that CMS ''remove prescription drug expenditures from the Sustainable Growth Rate (SGR) determination.''

The Congressional Record is replete with statements by members from both sides of the aisle calling for permanent reform. What is missing, however, is the result. The record shows temporary patches and a ballooning problem.

The AMA does not support any motion to recommit that would have a temporary fix. How steep will cuts be after those four years? How many hundreds of billions of dollars will it then cost to fix this problem? Medical liability reform remains among the highest priorities of the AMA and all physicians. However, when Republicans controlled both chambers of Congress and the White House, capping damages could not be accomplished. We fail to see why you believe it is possible today. With less than seven weeks before Medicare rates are cut more than 21%, we need solutions that can be achieved quickly.

This should not be a partisan issue. Both sides of the aisle have professed a desire to permanently address this issue. The opportunity to advance permanent reform through passage of H.R. 3961 cannot be missed. We urge all members to vote for H.R. 3961.

Sincerely,

J. JAMES ROHACK.

H.R. 3961 is supported by a wide range of organizations representing patients, doctors and other providers, including: AARP; Air Force Association; Air Force Sergeants Association; Air Force Women Officers Associated; Alliance for Retired Americans; AMDA—Dedicated to Long Term Care Medicine; American Academy of Allergy, Asthma and Immunology; American Academy of Child and Adolescent Psychiatry; American Academy of Cosmetic Surgery; American Academy of Dermatology Association; American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Family Physicians; American Academy of Hospice and Palliative Medicine; American Academy of Neurology Professional Association.

American Academy of Ophthalmology; American Academy of Pain Medicine; American Academy of Pediatrics; American Academy of Sleep Medicine; American Association of Clinical Urologists; American Association of Hip and Knee Surgeons; American Association of Neurological Surgeons; American Association of Neuromuscular and Electrodiagnostic Medicine; American Association of Orthopaedic Surgeons; American College of Allergy, Asthma and Immunology; American College of Cardiology; American College of Chest Physicians; American College of Emergency Physicians; American College of Gastroenterology.

American College of Obstetricians and Gynecologists; American College of Osteopathic Internists; American College of Osteopathic Surgeons; American College of Physicians; American College of Radiation Oncology; American College of Radiology; American College of Rheumatology; American College of Surgeons; American Gastroenterological Association; American Geriatrics Society; American Logistics Association; American Medical Association; American Medical Group Association; American Osteopathic Academy of Orthopedics; American Osteopathic Association.

American Psychiatric Association; American Society for Clinical Pathology; American Society for Gastrointestinal Endoscopy; American Society for Metabolic and Bariatric Surgery; American Society for Radiation Oncology; American Society for Reproductive Medicine; American Society for Surgery of the Hand; American Society of Addiction Medicine; American Society of Anesthesiologists; American Society of Cataract and Refractive Surgery; American Society of Clinical Oncology; American Society of Hematology; American Society of Nephrology; American Society of Ophthalmic Plastic and Reconstructive Surgery; American Society of Plastic Surgeons.

American Society of Transplant Surgeons; American Thoracic Society; American Urological Association; AMVETS; Arizona Medical Association; Arkansas Medical Society; Army Aviation Association of America; Association of American Medical Colleges; Association of Military Surgeons of the United States; Association of the United States Army; Association of the United States Navy; California Medical Association; Chief Warrant Officer and Warrant Officer Association of the U.S. Coast Guard; College of American Pathologists; Colorado Medical Society.

Commissioned Officers Association of the U.S. Public Health Service, Inc.; Congress of Neurological Surgeons; Connecticut State Medical Society; Contact Lens Association of Ophthalmologists; Emergency Department Practice Management Association; Enlisted Association of the National Guard of the United States; Fleet Reserve Association; Florida Medical Association Inc.; Gold Star Wives of America; Hawaii Medical Association; Heart Rhythm Society; Idaho Medical Association; Illinois State Medical Society; Indiana State Medical Association; Infectious Diseases Society of America.

International Society for Clinical Densitometry; International Spine Intervention Society; Iowa Medical Society; Iraq and Afghanistan Veterans of America; Jewish War Veterans of the United States of America; Joint Council of Allergy, Asthma and Immunology; Kansas Medical Society; Kentucky Medical Association; Louisiana State Medical Society; Maine Medical Association; Marine Corps League; Marine Corps Reserve Association; Massachusetts Medical Society; MedChi, The Maryland State Medical Society; Medical Association of Georgia.

Medical Association of the State of Alabama; Medical Group Management Association; Medical Society of Delaware; Medical Society of the District of Columbia; Medical Society of the State of New York; Medical Society of Virginia; Michigan State Medical Society; Military Chaplains Association of the United States of America; Military Officers Association of America; Military Order of the Purple Heart; Minnesota Medical Association; Mississippi State Medical Association; Missouri State Medical Association; Montana Medical Association; National Association for Uniformed Services.

National Committee to Preserve Social Security and Medicare; National Guard Association of the United States; National Medical Association; National Military Family Association; National Order of Battlefield Commissions; Naval Enlisted Reserve Association; Nebraska Medical Association; Nevada State Medical Association; New Hampshire Medical Society; New Mexico Medical Society; Non Commissioned Officers Association; North Carolina Medical Society; North Dakota Medical Association; Ohio State Medical Association; Oklahoma State Medical Association.

Oregon Medical Association; Pennsylvania Medical Society; Renal Physicians Association; Reserve Enlisted Association; Reserve Officers Association; Rhode Island Medical Society; Society for Cardiovascular Angiography and Interventions; Society for Maternal-Fetal Medicine; Society for Vascular Surgery; Society of Critical Care Medicine; Society of Gastrointestinal and Endoscopic Surgeons; Society of Gynecologic Oncologists; Society of Hospital Medicine; Society of Interventional Radiology; Society of Medical Consultants to the Armed Forces.

South Carolina Medical Association; South Dakota State Medical Association; Tennessee Medical Association; Texas Medical Association; The Endocrine Society; The Retired Enlisted Association; The Society of Thoracic Surgeons; United States Army Warrant Officers Association; USCG Chief Petty Officers Association; Utah Medical Association; Vermont Medical Society; Veterans of Foreign Wars; Washington State Medical Association; West Virginia State Medical Association; Wisconsin Medical Society; Wyoming Medical Society.

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair reminds Members on both sides of the aisle to direct their remarks to the Chair.

Mr. BARTON of Texas. Mr. Speaker, I'm not used to dealing with a warm and fuzzy PETE STARK. I have to admit that was a very good speech.

Mr. Speaker, I yield 1 minute to my good friend from Michigan from the Energy and Commerce Committee, Mr. ROGERS.

Mr. ROGERS of Michigan. Mr. Speaker, the SGR fix is incredibly important, but this approach is disingenuous at best. Let's go back quickly.

In 2008 the Medicare Improvement for Patient and Providers Act, sponsored by my friends on the other side of the aisle, had a 21 percent cut to go into effect for doctors this year. Your bill, your issue, your 21 percent. And you come here today knowing full well this bill will go nowhere.

Why this is disingenuous is because 2 weeks ago, you added about 16 million people to Medicaid that shorts doctors hundreds of millions of dollars in reimbursement every single year. And, oh, by the way, you tax doctors, and everything in their operation; their costs go up. And here's the thing: you cut a half trillion dollars out of Medicare, hospitals, home health services, nursing homes, hospice care. You cut Medicare a half trillion dollars. You know this bill will go nowhere.

This is an easy fix. Let's work together. Let's find some offsets. Let's fix it for doctors. And, by the way, let's go back and take back that money that you have cut, a half trillion dollars, out of Medicare for the lives and betterment of seniors.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair reminds Members on both sides of the aisle to address their remarks to the Chair.

Mr. STARK. Mr. Speaker, at this time I'm delighted to yield 1 minute to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. This bill is about more than the reasonable desire of physicians for reimbursement rates that cover their actual cost and fairly compensate their work. It is about access

to quality health care and your ability to choose the doctor best for you.

When accepting new Medicare patients means losing money, fewer physicians can accept new patients. In 1997, a Republican Congress enacted a payment formula that never worked, and then they kept everyone guessing year after year as to what kind of gimmick they would come up with in lieu of the next year's payment cut.

Now we have revised their flawed formula and prevented what could be up to a 40 percent cut for physicians. Our bill will not only help seniors and the disabled, but it will help many members of the active duty military and our veterans who rely on TRICARE. Our troops should never have to worry whether their family can get the care and the doctor that they need.

Instead of another Republican Band-Aid, we offer a cure for what ails the Medicare-TRICARE formula. Today is one time that the ''just say no'' party ought to say ''yes'' to good public policy, which is supported by the Texas Medical Association and medical societies across the country.

□ 1445

The SPEAKER pro tempore. The gentleman from Texas (Mr. BARTON) has 1 minute remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield myself the balance of the time.

I'd like to put into the RECORD a statement from the vice chairman of the American Medical Association on March 20, 1997, where they went on record before the Ways and Means Committee subcommittee supporting the current system. And now, I understand and I accept what Subcommittee Chairman STARK said, that mistakes have been made, and I think, in hindsight, both sides can agree that a mistake has been made.

It is my opinion, and I think most of the Republicans would share this opinion, that this is not the solution. When all you do is change which formula gets reimbursed, either primary care or specialist, but you use the same underlying formula, the same lack of enforcement, that's not, in my opinion, a fix. So respectfully, I believe that we should defeat this bill and then work together.

I do sense some bipartisanship on this floor. Let's work together to come up with a real fix. It will not be easy. It's not easy to come up with $350 billion. It's not easy to allocate that. It's not easy to change the formula to something that more accurately reflects the costs of practicing medicine in the modern era. But, we can do it. This is not the solution. I hope we'll vote this down.

As has been pointed out, this bill isn't going anywhere in the Senate. This is an act, in my opinion, of paying off a political debt to the American Medical Association for endorsing the larger health care bill several weeks ago. Please vote ''no.''

STATEMENT OF THOMAS R. REARDON, M.D., VICE CHAIR, AMERICAN MEDICAL ASSOCIATION

Mr. Chairman, my name is Thomas R. Reardon, M.D. I am a general practitioner from Boring, Oregon, and a member of the Board of Trustees for the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I thank you for this opportunity to testify before the Subcommittee today regarding Medicare physician payment issues.

A wide range of experts have independently concluded that, despite Medicare's clear success in improving the health status of our elderly and disabled citizens, the program cannot be sustained without fundamental restructuring. The Hospital Insurance Trust Fund faces bankruptcy in five years or less, and Medicare's current overall expenditure growth cannot be sustained. Medicare faces a much more serious long-term problem as the ''baby boom'' generation ages and the number of workers paying taxes for every Medicare beneficiaries will decline from 3.9 currently to only 2.2 in the year 2030.

The high growth rates for many of the services are due to a combination of factors, including increased beneficiary demand for new services, flaws in payment rules which encourage high volume growth in some categories of service, insulation of most beneficiaries from cost considerations, and ineffective approaches to cost control. However, as the chart below indicates, physician spending growth is well below the rate for any other major sector of Medicare, and well below overall Medicare growth. The AMA is pleased that the President's 1998 budget proposal explicitly recognizes this fact.

We are also pleased that the Administration's budget supports the development of innovative provider sponsored organizations in order to offer greater choice to Medicare beneficiaries. We believe these types of options hold the promise of enhancing beneficiary choice while controlling Medicare's costs. The AMA also supports the President's investment in preventive health care to improve seniors' health status by covering colorectal screening, diabetes management, and annual mammograms without copayments, and by increasing reimbursement rates for immunizations to ensure that Medicare beneficiaries are protected from pneumonia, influenza and hepatitis.

Unfortunately, the Administration's budget primarily adopts the strategy of cutting physician and other provider payments in hopes of getting more services for less money. We believe this approach will ultimately divorce the Medicare system and its beneficiaries from the mainstream of American medical care, while postponing the major restructuring needed for Medicare's long-term survival. In the meantime, the long-term problems will only grow larger, requiring more draconian and expensive solutions.

AMA'S PROPOSAL FOR MEDICARE TRANSFORMATION

The AMA has a plan which addresses both the short and long-term problems with Medicare, while preserving the bond of trust between a patient and physician that makes medicine unique. The AMA's Transforming Medicare proposal is based on the idea of a competitive market-driven system as the best option for the future of the Medicare program because it offers more choice to senior citizens and the disabled. We must give the patient both the opportunity and the responsibility to make wise prospective choices of physician and health plan, with the reasonable opportunity to change either if they prove unsatisfactory.

Our plan would modernize traditional Medicare, eliminating the need for Medigap, while preserving the security and quality of care beneficiaries now receive. It would create a new MediChoice option, which would provide a broad menu of health plan choices for Medicare beneficiaries to choose from, including medical savings accounts and provider sponsored organizations. And finally, it would ensure that a healthy Medicare is available for future generations. The AMA would welcome the opportunity to discuss our Transforming Medicare proposal with the Subcommittee in greater detail at an appropriate forum.

IMPROVING THE PHYSICIAN PAYMENT SYSTEM

The Administration's 1998 budget proposal targets $5 billion in savings over five years from refinements to the Medicare physician payment schedule. In particular, the Administration proposes moving to a single conversion factor (CF) for the payment schedule, and replacing the current Medicare Volume Performance Standard (MVPS) update formula with a Sustainable Growth Rate (SGR) formula.

Under the Administration's budget proposal, the overall payment update for 1998 would be set at 1.9%, yielding an overall CF of $36.63 in 1998. With the move to a single CF of $36.63, surgical service payments would fall by 10.6% compared to 1997 levels, while primary care payments would increase by 2.4% and other service payments would increase by 8.2%. The payment reductions for surgical services are further exacerbated by the implementation of resource-based practice expense relative value units scheduled for 1998, as discussed below.

The AMA has consistently sought a return to a single growth standard and conversion factor for physician services. We adopted this position well before any indication of which services would benefit from multiple standards. At our Annual House of Delegates meeting in 1996, AMA policy was modified to adopt a compromise that responds to two realties. First, because moving to a single conversion factor could lead to large single year cuts for some services and specialties, we support a transition of as close to three years as possible. Second, because we also recognize that one of the purposes of a transition is to allow those who face cuts time to adjust, and that there has been ''fair notice'' of a shift to a single conversion factor, our House of Delegates voted that the ''clock should start running'' on such a transition on January 1, 1997.

In addition to moving to a single conversion factor, the AMA supports replacing the MVPS system of updating physician payments. There is widespread agreement that the current method of updating physician payments, the MVPS system, is fundamentally flawed. The Congress, the Administration, and the Physician Payment Review Commission (PPRC) have all proposed replacing the current MVPS update formula with a sustainable growth rate (SGR) formula, which uses real per capita gross domestic product (GDP) to adjust for volume and intensity.

The Administration's fiscal year 1998 budget proposes implementing an SGR formula, with the volume target in the SGR formula initially set at growth in real per-capita GDP plus one percentage point. However, the Congressional Budget Office (CBO) scoring of the proposal apparently failed to yield the targeted savings of $5 billion in savings from the Medicare fee schedule, and the volume allowance in the SGR was reportedly reduced to GDP+0.

In general, the AMA supports implementing the SGR approach as a needed correction for the MVPS. Fundamentally, the question for policymakers is determining the level of annual spending growth for physician services that best balances patient care

needs and the federal budget. Under the current MVPS physician update formula, the projected Medicare payment level for physicians is a steep actual decline, while hospital and other provider payment rates go up, as the chart below indicates. Although these non-physician services are unlikely to see their full projected increases, their budget savings will be charged against this rising baseline, while further savings from physicians require even steeper cuts.

Budget reconciliation for Medicare should reflect the fact that physician spending is under better control than any other major Medicare segment, and that the budget baseline already assumes steep annual payment cuts. Physician practice costs, as measured by the Medicare Economic Index (MEI), continue to rise while physician reimbursement under Medicare is projected to fall. Physicians are only asking for the opportunity to have Medicare payments keep up with the costs of providing care to Medicare beneficiaries, and are willing to accept the challenge of maintaining volume growth at current low levels.

While we believe that MEI is the appropriate goal for physician updates, we understand that budgetary constraints may not presently allow for a full MEI update for physicians. Physicians are willing to do their part to put Medicare's fiscal house in order, as we have repeatedly done in the past. Physicians, who accounted for 32% of combined physician and hospital Medicare spending from 1987 to 1993, absorbed 43% of Medicare provider cuts over the same time. We would be willing to accept GDP+2 under an SGR system as a temporary measure, if there were assurances that this could be increased to cover MEI once the necessary Medicare savings were obtained. In contrast, under GDP+O as the Administration proposes, physician payments would continue to fall well below MEI, as they are projected to do under the current MVPS system.

Given a new SGR, with a realistic growth allowance, we could also support a new ceiling on positive MVPS adjustments, which would provide direct financial benefits to the federal budget if actual volume is below target. Moreover, the federal government receives a very real additional benefit—the ability to pay for the payment rates needed to maintain the viability of Medicare fee-for-service out of reduced service volume. At the same time, like the PPRC, we believe it essential to maintain the current 5% maximum payment reduction from the MEI (increased from 3% by OBRA 93) and to reject Administration proposals to lower the floor to MEI minus 8.25%.

RESOURCE-BASED PRACTICE EXPENSE

As mentioned above, many physicians face additional extreme payment reductions due to the implementation of the resource-based practice expense in 1998. The Social Security Act Amendments of 1994 requires the Health Care Financing Administration (HCFA) to implement a ''resource-based'' practice expense component of the Medicare fee schedule by January 1, 1998. That is, the payment for this component—which represents over 40 percent of the payment for physician services—is to be based on the actual expenses incurred in delivering each service. Currently, the practice expense allowance is derived from a formula based on the prior reasonable charge payment system.

The AMA supports resource-based practice expenses so long as they reflect actual practice expenses, but is seeking a one-year extension of the implementation date. The 1994 legislation said that HCFA should ''recognize the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings.'' HCFA contracted with Abt Associates to conduct a two-part study of 3,000 physician practices expenses. When the survey was pulled back due to poor response rates, HCFA was left without adequate data to meet the intent of the law.

HCFA is relying primarily on data derived from clinical practice expert panels, or CPEPs. Early review of the recently-released CPEP findings suggest that they contain a number of errors. HCFA has even rejected certain direct costs that its expert panels found were part of the cost of surgery when doctors supply their own staff and supplies in hospital operating rooms. The AMA and medical specialties are working to identify and correct those flaws but more time is needed.

Those who want to adhere to the current January 1, 1998, deadline argue that any problems can be corrected later through a refinement process similar to the one used when new work values were implemented in 1992. The AMA believes this is an inappropriate comparison. HCFA invested nearly three times as much time and money on the design of new work values as it has spent to revise practice expense values. Whereas thousands of doctors were surveyed to come up with the work values, in the end, there was no broad survey of practice expenses. Simply put, with work values, the product being tested was much further along in the development process than is now the case with practice expense values.

Opponents of an extension also maintain that there is no point in waiting another year because the demise of the indirect cost survey shows that it will never be possible to collect this information independently. We believe that with another year, HCFA could develop alternative relative values that bear some relationship to actual practice expenses. There would be adequate time to validate and correct the CPEP data. Better indirect cost allocation methodologies could be developed and tested. Missing data could be collected, perhaps through an expansion of existing surveys.

The cuts HCFA projected in January are so extreme that they would nearly eliminate practice cost reimbursement for some procedures and specialties. Many inpatient surgical procedures and two specialties could suffer cuts of more than 80% in their practice expense values, and at least 40% in their total payments. Under HCFA's projections, payments for many surgical procedures would fall below Medicaid levels. Thus, there is good reason to fear that if Medicare makes deep cuts in its payments for complex procedures, doctors performing these services may find that they can no longer afford to accept Medicare patients.

In addition, even some of the specialties which seem relatively unscathed in HCFA's projections could actually experience significant cuts if other payers pick up the new Medicare values because the projections do not show the impact of cuts in procedures usually done on patients under age 65. To impose such deep payment cuts based on such spotty research seems certain to undermine physician support for the RBRVS.

The AMA urges Congress to: (1) extend the resource-based practice expense implementation date by one year to January 1, 1999, in order for HCFA to incorporate data on physicians' actual practice expenses into the new relative values; (2) direct HCFA to give physicians the opportunity to review the practice expense data and assumptions six months prior to issuing the proposed rule; and (3) instruct HCFA to take whatever steps may be necessary to ensure that implementation of the new values will not have a negative effect on physicians' ability to provide high quality medical services to Medicare beneficiaries.

OTHER PHYSICIAN PAYMENT ISSUES

Assistants at Surgery

The Administration is proposing to save $400 million over the next five years by making a single payment for surgery. This means that the additional payment Medicare now makes for a physician assisting the principal surgeon in performing an operation would no longer be made. Instead, the payment amount for the operation would have to be split between the principal surgeon and the assistant at surgery. We believe this provision dangerously imposes financial disincentives for the use of an assistant at surgery. The AMA supports efforts to develop guidelines for the appropriate use of assistants at surgery, but believes that patient care should not be compromised in search of Medicare savings. The professional judgment of surgeons regarding the need for an assistant at surgery for a specific patient must be recognized, even for operations in which an assistant ordinarily may not be required. Congress has considered and rejected this proposal in the past, and we urge the Subcommittee to reject it again.

High Cost Medical Staff

The Administration proposes to reduce Medicare payments for so-called high cost hospital medical staffs. This proposal is not new. In its 1994 Annual Report to Congress, the PPRC concluded that such a ''provision's disadvantages . . . outweigh its advantages.'' The Commission went on to note that such a provision: ''may have unintended effects on physician behavior, including a shifting of admissions away from hospitals with the high-cost designation. The provision would also increase the cost and complexity [of] administering the Medicare program.''

In some cases, the physicians responsible for a hospital's medical staff being designated ''high cost'' for a given year might simply take their patients elsewhere, leaving the remaining physicians on staff to bear the financial consequences, with potentially serious repercussions for the affected hospital. Finally, the proposal could have the effect of inappropriately reducing payments to physicians who treat a sicker patient population. In the absence of a sound methodology to measure differences in the severity of illness of the patient population being treated by the medical staff, it is too risky to put in place a formula-driven process that could inappropriately lower payments for treating patients who are more expensive to treat because they are sicker.

Centers of Excellence

The Administration proposes to expand what it calls the ''Centers of Excellence'' demonstration project, under which Medicare makes a bundled payment to participating entities covering both physician and facility services for selected conditions, such as coronary artery bypass operations. We are concerned that these demonstration projects do not offer a potential increase in quality and cost-effectiveness, and that these ''centers of excellence'' in fact emphasize cost-cutting rather than excellence. We also find the name ''centers of excellence'' inappropriate in that it implies that institutions participating in this payment arrangement provide higher quality services than non-participating institutions.

FRAUD AND ABUSE

The AMA strongly opposes the Administration's efforts to repeal the fraud and abuse safeguards included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which would eliminate the obligation of the Departments of Justice and Health and Human Services to issue advisory opinions on the anti-kickback statute, reduce the government's burden of proof for

civil monetary penalties, and repeal the risk sharing exception to the anti-kickback statute.

Fraud and abuse has no place in medical practice and the AMA is committed to setting the highest ethical standards for the profession. For those who wish to comply with the law, the incidence of misconduct can be greatly reduced by setting standards of appropriate behavior, disseminating this information widely, and designing and implementing programs to facilitate compliance. HIPAA provides new and much needed guidance by requiring HHS to establish mechanisms to modify existing safe harbors, create new safe harbors, issue advisory opinions, and issue special fraud alerts. This guidance will allow physicians, hospitals and insurers to develop efficient and effective integrated delivery systems that will benefit Medicare, Medicaid and the private health care marketplace.

In the area of civil monetary penalties (CMPs), HIPAA requires that the Inspector General establish that the physician either acted ''in deliberate ignorance of the truth or falsity of the information,'' or acted ''in reckless disregard of the truth or falsity of the information.'' The AMA fought long and hard to preserve this clarified standard in the face of huge opposition. This standard makes the burden of proof for imposing CMPs under HIPAA identical to the standard used in the Federal False Claims Act, and there is no reason that two enforcement tools designed to address the same fraudulent behavior should have different standards of proof. Moreover, this section provides important protection for physicians who may unwittingly engage in behavior that is impermissible.

Finally, the AMA strongly opposes the Administration's proposal to eliminate the new risk sharing exception to the anti-kickback law provided in HIPAA. The expansion of managed care in today's health care market requires additional exceptions to the anti-kickback laws so that more flexibility in marketing practices and contractual arrangements is afforded. The future of the Medicare and Medicaid programs depends upon the ability of competing plans to offer quality alternatives to the existing program. HIPAA provides a much needed exception to the anti-kickback law for certain risk-sharing arrangements which will facilitate the development of innovative and cost-effective integrated delivery systems.

CONCLUSION

Americans can no longer postpone tackling fundamental reform of the Medicare program. Failure to do so is certain to prove even more costly for the millions of Americans who expect to be able to rely on this program in the future, as well as those working Americans who are called upon to help finance it. Simplistic budget-cutting has not resulted in cost-control over recent years; on the contrary, price controls have had the perverse effect of exacerbating Medicare's fiscal crisis and severely threatening the promised access of beneficiaries to medical care.

However Medicare is reformed, it will be our overriding goal to ensure that the change not damage the essential elements of the patient-physician relationship. Above all, reform should not break the bond of trust between a patient and physician that makes medicine unique. By that we mean:

All patients must remain free to choose the physician they feel is best qualified to treat them or individually elect any restrictions on choice;

All patients, including those with chronic conditions and special health or financial needs, must have access to any needed service covered by Medicare;

No restrictions on information about treatment options and no financial incentive program can be allowed to interfere with the physician's role as patient advocate;

Both patients and physicians must have complete, easily understood information about the Medicare program, and a right to raise questions, voice grievances, and to have them responded to in a fair, effective process; and

Patients must be protected from unscrupulous or inept health plans, physicians, and other providers.

Americans who depend on the Medicare program for their medical and health care, as well as those who will rely on it in the future, should not have to worry about whether benefits promised them will be forthcoming. The AMA looks forward to working with the Subcommittee and the 105th Congress in protecting Medicare for our seniors and saving it for our children.

Mr. STARK. Mr. Speaker, I am pleased at this time to recognize a distinguished member of the Ways and Means Committee, Mr. NEAL of Massachusetts, for 1 minute.

Mr. NEAL of Massachusetts. Mr. Speaker, I rise in support of this Medicare Physician Payment Reform Act, and remind our friends on the other side that this is similar to the 2-minute drill. We do this every year. It's like the 2-minute warning in professional football. H.R. 3961 is about preserving patient choice, which is a fundamental element of our health care system, and very important to the reform measure that we passed about a week ago.

This legislation will ensure that seniors on Medicare and TRICARE across America continue to have access to care and to the physician of their choice. But conversely, this bill also provides physicians with the certainty they need and have been missing to operate their offices in a predictable way and to continue to serve Medicare patients.

It eliminates the steep payment cut scheduled for next year, a cut that, if it were allowed to happen, could reduce physician access across the country. H.R. 3961 is a good piece of legislative work. It increases payments to primary care providers for office visits, and it encourages the formation of accountable health care organizations. It goes a long way in preserving the vital patient-doctor trust contract and to strengthening that relationship.

I urge support of this legislation.

Mr. CAMP. Mr. Speaker, I yield myself 2½ minutes.

The Medicare system paying for doctors is broken. It's broken badly, and on that, I don't think there's any disagreement. The question before us today is not whether to fix the so-called ''sustainable growth rate formula,'' but how.

Time and time again, Republicans have supported America's doctors, while always paying for a so-called doctor fix. And the fact remains true today. It's irresponsible for the Speaker to force this House to choose between protecting doctors and seniors today and protecting our children's future. The bill before us directly adds at least $210 billion to the deficit, plus another 50 billion in added debt payment, and as The Washington Post noted, the budget gimmicks mask the true costs, which are closer to $300 billion. So much for health care reform not adding one dime to the deficit.

Adding insult to injury, the bill before us doesn't even solve the underlying problem with the SGR. The Democrats' new ''targeted growth rate'' would allow doctors to face cuts again as soon as 2011. We can and should do better by our doctors, our seniors and our children.

Republicans are offering a better alternative, a 2 percent increase in doctor and Medicare payments in each of the next 4 years that is fully paid for, primarily by implementing real medical liability reform, a proven way to cut wasteful health care spending.

It's telling that our colleagues on the other side prefer to pile up hundreds of billions of dollars in new debt on our children, instead of standing up to their friends in the trial lawyer lobby. For all of the talk about PAYGO, this bill makes a mockery of the majority's so-called commitment to fiscal responsibility. This is new spending and lots of it. It should be paid for, it must be paid for, and Republicans are offering a way to pay for it.

I reserve the balance of my time.

Mr. STARK. I'd like to recognize Mr. BLUMENAUER from Oregon for 1 minute, but pending that, I yield myself 30 seconds to respond to my distinguished colleague and ranking member of the Ways and Means Committee that we debated this back in July, and that all of us agreed and voted for the fix that we're talking about today. And I hope that we could continue that. It was done on a bipartisan basis at that time. It was probably the only part of the bill that was bipartisan, but we did all vote for it and voted for exactly what we're talking about today, and I hope we could get those votes again.

I yield to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. I appreciate the gentleman's courtesy. This is a necessary budget adjustment, the consequence of the Republican gimmick that I voted against in 1993 because it was an artificial attempt that nobody had an expectation we were actually going to do. Indeed, every single year, except one, the Republicans blinked and kicked the can down the road.

We are facing up to the problem today in a comprehensive way, not holding doctors and their patients hostage. Health care reform actually moves us in the direction to be able to reduce costs in the long term, and I'm optimistic that what the House has already done will move us in that direction.

But whether or not reform is enacted, failure to pass this inflicts unacceptable damage on our constituents. This legislation gets us off the merry-go-round. I would strongly urge my colleagues to vote with us, my Republican friends not to vote ''no,'' but

work with us with a strong, resounding vote of support, and then work with the Senate to adopt this reasonable long-term adjustment.

Mr. CAMP. I yield 2 minutes to the ranking member of the Health Subcommittee, the distinguished gentleman from California (Mr. HERGER).

Mr. HERGER. Mr. Speaker, while I rise today in support of reversing the devastating Medicare cuts for physicians, I also rise in opposition to passing the buck to our children and grandchildren.

Mr. Speaker, our government is facing a severe and unprecedented debt crisis. Yet, despite the President's pledge that health care legislation won't add one dime to the deficit, we're voting today on a health care bill that adds 2 trillion dimes to the debt, while piling trillions of dollars more onto Medicare's unfunded liabilities.

Mr. Speaker, the American people are tired of these budget games. Two weeks ago, 219 Members of the Democratic majority voted to cut Medicare by $500 billion. We could have taken a fraction of those savings and kept them within Medicare to pay for this much-needed relief for physicians. It would have passed with a huge bipartisan vote. But, instead, the majority decided to raid Medicare and spend the money on a new government-run health program.

Republicans will be offering an alternative to ensure that doctors in Medicare are paid appropriately, and protect them from frivolous medical lawsuits, all without adding to the debt.

I urge the Speaker to stop the political games and allow the House to vote on our responsible solution. It's the right thing to do for our doctors, it's the right thing to do for our seniors, and it's the right thing to do for the future of our country.

Mr. STARK. Mr. Speaker, could I inquire as to the remaining time on either side?

The SPEAKER pro tempore. The gentleman from California has 7 minutes and the gentleman from Michigan has 11½ minutes.

Mr. STARK. At this time, Mr. Speaker, I'm delighted to yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. First thing we have to get straight here is that the past administration masked the costs of our one-sided tax cuts in 2001 and 2003, unpaid for; masked the costs of two wars, never in the base budget; masked the costs of taking care of our returning brave soldiers. You have been the masters of masks. And now you're advising Democrats? Case closed.

Mr. Speaker, today we have the opportunity to vote on legislation for which many of us here have hoped for years, a permanent solution to the flawed Medicare physician payment formula. I implore my colleagues to set aside partisan bickering. Each year for the past 7 years, both Republican Congresses and Democratic Congresses have stepped in to preserve seniors' access to care by preventing steep cuts to physician payments. Each year.

The sustainable solution before us today deserves bipartisan support. If we're truly serious about enacting comprehensive health reform then we will pass this vital legislation. Providing a realistic, long-term solution that embraces a legitimate effort to rein in spending while recognizing—

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. STARK. I yield the gentleman an additional 15 seconds.

Mr. PASCRELL. To rein in spending while recognizing the value of primary care is a necessary foundation to true reform. Without it, it's like building our house on a foundation of sand that not only jeopardizes access to care for 45 million seniors and individuals with disabilities but also has important consequences for our entire physician workforce.

Mr. CAMP. I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Texas (Mr. BRADY).

Mr. BRADY of Texas. Mr. Speaker, unfortunately, this conversation is not about doctors. It's about a budget gimmick to try to hide the true cost of NANCY PELOSI's health care takeover. There is a right way and there is a wrong way to help our doctors get paid fairly under Medicare. But because not one dime of this bill is paid for, it forces Americans to borrow another $279 billion from China and pass the bill of debt down to our grandchildren to pay, all to hide the cost of this health care reform in Washington.

This is irresponsible, and it's the wrong way. I support the Republican alternative. We give our doctors cost-of-living increases, but we pay for them by chasing frivolous lawsuits that drive up the costs of medicine out of our system. So we help our doctors and we help the patients at the same time.

And I want to finish with this: This Medicare, the way we pay our doctors, it's a great taste, sort of a look into the future of what happens when the government is going to run your health care decisions. Not paying doctors fairly is how Medicare rations care today, and it's the main reason seniors have difficulty finding a doctor. This is a peek into the future when Medicare makes budget decisions about your life and death medical decisions. This is the future, and it's frightening.

□ 1500

Mr. STARK. I reserve the balance of my time.

Mr. CAMP. At this time, Mr. Speaker, I yield 2 minutes to the ranking member of the Budget Committee and a distinguished member of the Ways and Means Committee, the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Speaker, there is so much irony surrounding this bill here.

First of all, everybody knows this bill is not going anywhere because the Senate already defeated a cheaper version because it created a huge deficit.

I have a score from the Congressional Budget Office which I will insert into the RECORD that says this thing raises the deficit by $210 billion. What's more ironic is that the majority, which put in this huge PAYGO system, has just swept it aside and decided to say, No, the CBO is wrong, this doesn't increase the deficit. It costs nothing.

Why did they do that? They did that because they're trying to pass this health care bill and suggest that it doesn't cost anything.

I have a letter from the CBO today that simply says when you merge these bills together—because they are together; in fact, this doc fix bill was in the original bill in the first place—that it raises the deficit, now and into the future. It adds more than many dimes to the deficit now and into the future. It breaks the President's pledge and promise on how health care reform will be conducted.

What is even more ironic are the doctors who are telling us to fix this—and we all want to fix this—is that we can't even bring a bill to the floor to fix it without raising the deficit. That's irony.

What I also find especially ironic are that some physicians say fix this but then create this new system, which is basically to have Medicare for everybody else. So if they think the SGR is a problem now, just wait until you see this system writ large throughout all of American health care. That is a mistake.

We should do this in a bipartisan way, fix it without cranking a huge hole in the deficit, and if the majority would have allowed us to bring a bill to do that, we could have done just that. It's cynical. We know this bill is not going anywhere. So let's get back to work and fix this problem without cranking up a huge hole in the deficit.

Mr. STARK. I yield myself 30 seconds, Mr. Speaker, just to remind the distinguished gentleman from Wisconsin that he and 14 of his colleagues voted for this bill in the Ways and Means Committee last July.

I don't mind mixing it up with the health care reform, but it's not. It's the doctor fix.

Mr. RYAN of Wisconsin. Will the gentleman yield?

Mr. STARK. In just a moment, yes.

The important thing is that if we move this aside, we're correcting the mistake that was made. Let's forget about who made it. It was there.

Now this may not be the end-all correction, but there is no reason that we couldn't come back next year if we find that the formula doesn't work.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. STARK. I will yield myself an additional 30 seconds.

If we don't do it and we do the 4-year fix that you, MIKE, suggested, or the 3-year, and then it doesn't work, we will have $400 billion to correct.

My point is this. If we could remove it for a moment from the discussion on the overall health reform bill—which we can have a spirited discussion on—this is a technical fix which all of your members supported on a bipartisan basis.

Mr. RYAN of Wisconsin. Will the gentleman yield?

Mr. STARK. I yield to the gentleman from Wisconsin.

Mr. RYAN of Wisconsin. If you recall during the debate, at the time we said we should be paying for this and let's come together to find a solution to fix this without raising the deficit. This was inside of your health care bill to begin with. So it's difficult to say that these two things aren't connected.

Mr. STARK. Well, as I say, the gentleman supported it a few months ago.

At this point, Mr. Speaker, I'd like to yield 1 minute to the gentlelady from Nevada (Ms. BERKLEY).

Ms. BERKLEY. I thank the gentleman from California for yielding me the time.

I have had the fastest growing senior population in the United States for many decades in a row. My seniors need health care and they need to be able to see a doctor. But every year when we get to the end of the year, we play this ridiculous game of whether or not we're going to provide a doctors fix and be able to reimburse the doctors for seeing our senior patients under the Medicare program. And every year I receive telephone calls from doctors in the Las Vegas area telling me that if in fact they don't get reimbursed as they should, that they will not be able to continue seeing Medicare patients.

Now, short of me going to medical school so I could go home and take care of the seniors in my district when I go home on the weekends, we better figure out a way of adequately reimbursing the doctors—not doing it on a year-to-year basis which gives them an accounting nightmare—and being able to provide stability for the Medicare system so that the millions of seniors in this country that depend on the Medicare program for their health care needs to be met, that we are able to meet them. I urge that we support this bill.

Mr. CAMP. Mr. Speaker, I yield 1 minute to a distinguished member of the Ways and Means Committee, the gentlewoman from Florida (Ms. BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise today in opposition to the Medicare Physician Payment Reform Act.

Let me be clear. We all want to fix the flawed physician reimbursement rate. Without a fix, physicians around this country may be closing their practices and turning seniors away. This is an extremely serious matter. However, Democrats are using physicians and seniors as political pawns and playing games with people's livelihoods. It's unconscionable that the AMA traded their support for $210 billion.

The Congressional Budget Office has said that this bill will increase Medicare part B premiums to our Nation's seniors by $50 billion. This bill will add nearly a quarter of a trillion dollars to our Nation's exploding deficit. My constituents want to know how in God's name are we ever going to pay this debt down. I am one of the few Republicans who voted for PAYGO, and I'd like to see it being used instead of regularly waived as it is here.

This bill is fatally flawed, and I urge my colleagues to follow the lead of the Senate and reject this bill so we can work together on a solution.

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

Mr. CAMP. I yield 1½ minutes to the gentleman from Illinois (Mr. ROSKAM), a distinguished member of the Ways and Means Committee.

Mr. ROSKAM. I thank the gentleman for yielding.

Can you imagine what it would be like if this House at this time took President Obama's admonition seriously? A couple days ago he said this on his trip to China:

It's important, though, to recognize that if we keep on adding to the debt, even in the midst of this recovery, that at some point people could lose confidence in the U.S. economy in a way that could actually lead to a double dip recession.

Can you imagine what would happen if this House came together and said, No, no, no, no, no. We're actually going to take this seriously. We're going to deal with this debt question, and we're going to lean into it in such a way that gives, what, a buoyancy to the American economy as opposed to continuing to drag down.

With all due respect to the majority leader when he was on the House floor a bit ago, he argued, in essence, don't worry about it because it's in the President's budget. Well, think about where that takes you. The President's budget is the problem. The President's budget doubled our national debt in 5 years and will triple that debt in 10 years, which is one of the reasons why Americans are so increasingly concerned.

Look, we all come together and we know the physicians need to be compensated fairly. We know that seniors ought not bear this burden. But why not work together to take the President's admonition seriously to take the debt question seriously and come up with a real fix?

Mr. STARK. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from California has 3¾ minutes, and the gentleman from Michigan has 5½ minutes.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Louisiana, Dr. BOUSTANY.

Mr. BOUSTANY. Mr. Speaker, as a physician I know directly about access problems that our seniors are having. Clearly we must protect seniors' access to physicians of their choice. I also know directly about the flawed formula for physician reimbursement. We all want to deal with it.

What we need to do is repeal the flawed SGR formula and replace it with a more equitable reimbursement for physicians that is paid for. This bill ignores over $200 billion in added deficit spending. It continues the same price-controlled formula for physicians. And it does not eliminate—let me repeat—it does not eliminate the tendency for physician cuts. Instead of providing a realistic, long-term solution, this bill spends borrowed money and basically increases the Medicare shortfall by $1.9 trillion.

I urge my colleagues, let's get real about this. I urge my colleagues to vote ''no'' on this bill. Let's support a real solution that protects patient access to a physician of their choice. Let's support a real solution that's honest with physicians and treats them fairly, and a solution that avoids massive debt passed on to our children and grandchildren.

Vote ''no'' on this bill.

Mr. STARK. I yield myself such time as I may consume, Mr. Speaker, to remind my distinguished friend from Louisiana that the American College of Cardiology, the Louisiana Medical Association, and most every medical association in the United States has endorsed the legislation.

I reserve the balance of my time.

PARLIAMENTARY INQUIRY

Mr. RYAN of Wisconsin. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. RYAN of Wisconsin. Mr. Speaker, clause 10 of rule XXI, what is known as the pay-as-you-go or PAYGO rule, provides a point of order against direct spending or revenue legislation that would increase the deficit, and the bill before us today increases the deficit by $209.6 billion according to the Congressional Budget Office. While there is no authority to reduce the estimated cost of legislation in the rules adopted by the House at the beginning of the 111th Congress, am I correct that the House has effectively modified the application of this rule on two separate occasions with respect to its application to Medicare legislation?

The SPEAKER pro tempore. In addition to its adoption of standing rules on January 6, 2009, the House has further exercised its rulemaking authority in section 421 of the current budget resolution, Senate Concurrent Resolution 13, and in section 2 of House Resolution 665.

Mr. RYAN of Wisconsin. Further parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. RYAN of Wisconsin. The first modification was made by the conference report on the FY 2010 budget

resolution adopted on April 29, 2009. Am I correct that the budget resolution provided authority to reduce CBO's deficit estimate of this legislation by up to $38 billion?

The SPEAKER pro tempore. The gentleman alludes to section 421(a)(2)(A) of the budget resolution, which the Chair will not characterize. The text speaks for itself and may be addressed by Members in debate.

Mr. RYAN of Wisconsin. Further parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. RYAN of Wisconsin. My understanding is that on July 22, in passage of that PAYGO bill, that the budget resolution was modified to allow the CBO estimate of the cost of the legislation to go up to $284 billion which could not be counted. Am I correct that even though the Congressional Budget Office says that this bill raises the deficit by $209.6 billion, the rule in place right now gives the chairman of the Budget Committee the ability to simply say that this costs nothing, that the score is zero.

Am I correct in saying that?

The SPEAKER pro tempore. This is not a parliamentary inquiry. Such commentary may be presented by the gentleman in his own voice by remarks in debate.

Mr. RYAN of Wisconsin. I thank the Chair.

Mr. STARK. Mr. Speaker, at this time I am pleased to yield 1½ minutes to the distinguished gentleman from North Carolina (Mr. ETHERIDGE).

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

Mr. ETHERIDGE. Mr. Speaker, I thank the gentleman for yielding time and for this bill.

You know, folks, Medicare is a vital lifeline for our seniors, but it's worthless if doctors can't afford to see Medicare patients. Seniors should be able to see the doctors they prefer, and fixing the doctor payment system will make sure that they have access to high quality care from people that they trust.

Countless doctors in my district have told me that they're happy to treat seniors, but they risk going out of business with current Medicare payments. We must make sure that they continue to be able to treat patients.

By fixing the doctor payment issue and including PAYGO, Congress is ending budget gimmicks and the reckless borrow-and-spend policies of the last decade.

I strongly support this bill, and I urge my colleagues to join me in strong support of our seniors and the physicians who keep them healthy.

Mr. Speaker, this bill deserves every Member's support.

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

□ 1515

When we reviewed this debate on this physician payment formula fix, clearly, this is something that we, both sides, agree needs to be addressed. But as you look at how this has evolved, initially this provision was part of the Pelosi-Obama health care bill. But when that 2,000-page bill came in at $1 trillion, this was pulled out, and then it was made a separate bill that be will magically merged into ObamaCare as that moves over to the Senate. And we have experts who have said this provision alone, without being paid for, could add to Medicare's unfunded liability as much as $1.9 trillion over a 75-year period. And obviously, with Medicare, we are looking at the long term. Given that there is already a $39 trillion hole in Medicare, this ends up making a commitment that will be borne by our children and grandchildren.

We believe that we should have the opportunity to offer an alternative that would be paid for, as every alternative over the years has been. And I know the other side has cited this vote in committee. That vote was simply, in the context of full health care reform, saying that health care reform needed to be paid for and we needed to be fiscally responsible.

We think this is a very important issue. Certainly, the public has weighed in on this incredible explosion in the debt over these last few months. And we believe that it is irresponsible to bring this bill to the floor, to make us choose between doctors and seniors and our children, and we believe that an alternative that is fully paid for is the right way to go.

With that, I yield back the balance of my time.

Mr. STARK. Mr. Speaker, I yield to the gentlewoman from Texas (Ms. JACKSON-LEE) for a unanimous consent request.

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Thank you very much, Mr. STARK.

I rise to support H.R. 3961 because it provides a payment for our doctors, allows seniors to keep their doctors, and is paid for.

Mr. Speaker, I am pleased to stand before you today in support of the Medicare Physician Payment Reform Act. This bill, which will finally put an end to the cycle of threats of larger and larger fee-cuts followed by short-term fixes, is long overdue. This bill will repeal a 21 percent fee reduction that currently scheduled right around the corner, January 2010.

Given the fact that Healthcare reform has been, and still is, a very lively and relevant topic over the recent months, the timing of this bill is apropos in that is intended to make our nations healthcare system more efficient. The importance of this bill is evidenced by its widespread support from a range of organizations representing both patients and doctors, including the American Medical Association, AARP, and the American Academy of Family Physicians just to name a few. Their support shows that there has been a need for better management of the Medicare system, and this bill presents the sustainable solution that physicians and patients alike have been looking for.

Proper management of Medicare funding ensures that the Medicare system will be able to properly support the medical needs of its intended beneficiaries. This bill will help promote the use of primary care and give access to the use of primary care practitioners in Medicare and throughout the healthcare system. By providing incentives to physicians, this bill will also encourage integrated care and increased communications amongst doctors on the care of their specific patients. These improvements to the Medicare system will result in a higher quality of care and ultimately, a healthier population of patients.

With so many Americans currently uninsured or receiving inadequate healthcare, it is paramount that the funds set aside to support Medicare are used wisely to provide the best possible care for patients.

In my home state of Texas, the need for a more efficient healthcare is more prevalent now than ever. One in four Texans, about 5.7 million people, or 24.5 percent of the state's population, has no health insurance coverage. An estimated 1,339,550 Texas children—20.2 percent of Texas children—are uninsured. According to the U.S. Census Bureau, Texas has the nation's highest percentage of uninsured residents. This poses consequences for every person, business and local government in the state who bear extra costs to pay for uncompensated care. If Medicare funding is allowed to be cut or capped, the number of uninsured will grow dramatically.

I realize that we must consider budgetary concerns while we champion the push for better quality healthcare, and the Medicare Physician Payment Reform Act does just that. It was drafted with fiscal responsibility in mind. We want to protect both the medical and fiscal health of our people and this bill takes steps to do just that. The cost of the bill is already included in the House-passed and President's budgets. This money represents the ongoing care and maintenance of the Medicare program. The legislation fully complies with the House-passed PAYGO requirements because the PAYGO legislation explicitly accommodates physician reform legislation that is designed to maintain current spending. As such, the bill, while it contains new reforms, represents continuation of an existing policy rather than new spending. H.R. 3961 will be coupled with Statutory PAYGO legislation when it is sent to the Senate.

The cost of addressing this problem will only grow in the future. In 2005 a permanent freeze for physician payments was scored as costing $48.6 billion; today, a policy with a similar score costs $210 billion. Delays today mean larger and larger price tags in the future and continuing damage to the Medicare program. Therefore prompt action on this issue is necessary and must be taken.

As we talk about fixing the issue of Medicare payments to physicians, this raises similar fixes that I proposed in H.R. 3962—The America's Affordable Health Choices Act of 2009. Specifically, I proposed two changes to Section 1156 of H.R. 3962, to prevent existing physician-owned hospitals from being forced out of business, amendments that enjoyed bipartisan support. First, to avoid harming existing physician-owned hospital projects, I proposed extending the date of the grandfathering provision of Section 1156 to

January 1, 2011 and by strengthening the requirements for Hospitals to qualify for an extension. Next, I suggested that we extend the cut-off date for determining the baseline number of beds and procedure rooms for purposes of the expansion prohibition (currently, date of enactment) to the same date proposed or the grandfathering provision.

Along with this, I share the concerns of health advocates that, as is, the public option in H.R. 3962 is not equipped to provide real competition to large mega insurance plans. As such, I proposed that H.R. 3962 incorporate Congressman KUCINICH's proposal to allow states to choose public insurance options more robust than the Federal plan.

I look forward to working with the leadership going forward to fix these items along with a system that each year cuts Medicare reimbursements to Physicians.

Mr. STARK. Mr. Speaker, I yield myself the balance of the time.

I again encourage my friends on the other side of the aisle to support this fix for the physician reimbursement. It was correct originally in our major health reform bill. The reason it was separated, I would have to admit, was purely political. We had to abide by the President's request that we did not exceed certain costs, and we separated it for that.

For those of you who suggest that the Senate may do nothing with this, I'm afraid we have to leave that to the American Medical Association and America's physicians. They will have to pressure the Senate to add this at some point in their deliberations. I think it's beyond us to do that, and my suspicion is that with the more than 150 medical societies around the country, they will be able to importune our friends on the other side of the Capitol.

Mr. Speaker, I believe that we will see a format of this bill facing us from the other side. I hope we do. We are talking about postponing any length of time increases, whether it's 4 years and we get $400 billion, whether it's a couple of years and we get $200 billion, there was a mistake made. The distinguished gentleman whom the current ranking member and I know so well is no longer with us. He is probably chuckling up his sleeve at the angst he has caused us.

But we recognize the mistake. We did try to fix it. We did try to fix it on a bipartisan basis. I know there are other issues that are tangential to this. I hope we can put these aside today. Take care of the physician fix. Hopefully we've got the formula right. As I said earlier to the distinguished gentleman from Wisconsin, we might not have it perfect, but we have some time in the next year or 2 to make those adjustments. I commit to you that we certainly will, and I hope that you would work with us to help correct it if that comes in the future so we can set this aside. It's a separate debate.

We are going to have a long and strenuous debate on health care reform as we go down toward the end of the year and into next year. And I look forward to that. But I would like to see this set aside so that we can see that the physician payment fix, which we all know has been facing us for years, is ended today and that we pass this bill.

I thank my friends on the minority side for their kindness in this debate and, Mr. Speaker, I urge passage of the bill.

Mr. REYES. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009. Over this past summer, physicians in my district consistently stressed the need to reform our flawed Medicare reimbursement formula to ensure continued access to care for our Medicare beneficiaries. I could not agree more. For the last several years, Congress has had to act to reverse reimbursement reductions that would have prompted many doctors to close their doors or refuse to see more Medicare beneficiaries. If we do not act today, physicians serving Medicare patients will see a 21 percent reduction in their reimbursements next year. A cut of this magnitude will reduce access to physicians for Medicare beneficiaries throughout the country. Today, we in the House of Representatives are demonstrating our commitment to permanently fixing this problem.

I am pleased that H.R. 3961 will eliminate this steep payment cut scheduled for 2010 and protect access to care for seniors and people with disabilities into the future. It will also help protect access for our men and women in uniform and their families, since physician payment rates in TRICARE are tied to those used by Medicare. By providing a boost to primary care providers through increased payments for evaluation and management services, such as routine office visits, we help our physicians and patients focus on preventive measures and general wellness. Above all, this important legislation will ensure fair and adequate payment for physicians who participate in Medicare.

The American Medical Association, AARP, the Military Officers Association of America, the American Academy of Family Physicians, the American College of Physicians, the American College of Surgeons, the Center for Medicare Advocacy, the Medicare Rights Center, and the National Committee to Preserve Social Security and Medicare support this legislation. Like them and many of my colleagues, I too support comprehensive reforms to Medicare physician payments that enhance efficient and high-quality care for beneficiaries that protect their choice of physicians. For these reasons, I urge my colleagues to vote in favor of H.R. 3961.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise today in support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009.

This important piece of legislation will repeal the 21 percent physician payment cut, which is scheduled to go into effect on January 1 and replace it with a 1.2 percent increase for next year.

It has been over a decade since the physician fee schedule was put in place to help control increases in Medicare payments to physicians. The Medicare program reimburses physicians who treat seniors using a complex formula that is based on a number of factors.

Unfortunately, payments for physician services matched the SGR and expenditure targets for only the first 5 years. Since then, the actual expenditures have exceeded the target by so much that the system is no longer realistic.

As we have learned in recent years the formula reduces payments to physicians when the economy goes down—a time when doctors are least able to absorb the extra costs. These payment reductions have caused many physicians to hold off on accepting new Medicare patients, withdraw from the program, or retire altogether.

In areas like mine that rely heavily on Medicare and Medicaid, we probably will not be in a situation where doctors stop taking Medicare. Rather, we will see access problems created by gap from physician retirements that is not filled by new crops of doctors willing to take Medicare patients. If we reach that point, Medicare will have failed in its mission to provide equality in access to health care for our senior citizens.

We passed H.R. 3962, the Affordable Health Care for America Act a couple of weeks ago, but we cannot successfully implement health care reform if we do not reimburse our physicians correctly. It is time for Congress to intervene and revamp the SGR formula and pass H.R. 3961.

Mr. KLEIN of Florida. Mr. Speaker, I rise in strong support of H.R. 3961, the Medicare Physician Payment Reform Act. This vital component to health care reform will finally eliminate the widely criticized Sustainable Growth Rate, or SGR, and implement a new, fairer system to pay our doctors and protect and strengthen Medicare for all our seniors.

Originally enacted in 1997, the SGR has been, in my opinion, an attempt to balance the budget on the backs of doctors and other providers, and this is not acceptable. Not only has the SGR failed to curtail spending, but in some cases it incentivizes volume of services instead of quality of care, and it may be expediting the shift from primary care services to specialty and sub-specialty services. As you well know, Mr. Speaker, the alarming shortage of primary care physicians remains one of the most pressing challenges to our health care system.

Make no mistake: passing this bill today is of the utmost importance for our seniors and our physicians. Since 2001, doctors have faced cut after cut in their Medicare reimbursements due to the flawed SGR. Each time, Congress stepped in at the 11th hour to block the cuts and provide increases to their pay to ensure that seniors can continue to see the doctors of their choice under Medicare.

We are facing the same alarming situation now due to the SGR. Doctors are facing a crippling cut of 21 percent in January 2010. Let me repeat that number so all my colleagues who intend to vote against this bill can hear this loud and clear. Doctors who care for our seniors are facing a 21 percent cut in their pay. It doesn't take an economist to know that if doctors face a 21 percent cut in their salary, they will stop taking Medicare patients.

I can't speak for my colleagues, but I will say this. When I came to Congress 3 years ago, I vowed to strengthen and protect Medicare for my seniors, and that means fixing once and for all the way we pay our doctors under Medicare. By passing this bill, seniors will not have to lose another night of sleep over whether they can be treated by the doctor of their choice. This bill will bring peace of

mind to thousands of seniors and health care professionals in South Florida.

This important legislation builds on the critical reforms that we passed in H.R. 3962, the Affordable Health Care for America Act, which will finally close the donut hole for seniors enrolled in Part D, allow for drug price negotiation in Medicare, and eliminate copayments for vital preventive services to our seniors. Combined with this permanent fix to the way we pay doctors, this Congress is following through on our promises to our seniors and strengthening Medicare for years to come.

This bill will also include an important component to reducing the federal deficit. The ''pay as you go'' principle of budget discipline requires Congress to offset any new spending with either cuts to existing programs or increases in revenue. It was in place during the 1990s when Congress balanced the budget and actually ran a budget surplus. Pay-Go was allowed to expire and now we have the situation we are in now.

As a deficit hawk, I am absolutely committed to balanced budgets and reducing our deficit. I am a very strong supporter of writing pay-as-you-go requirements into law. This is a common-sense principle that families follow around their kitchen tables every day, and the government should be no different. We can only buy what we can afford, and nothing more.

I urge my colleagues to support H.R. 3961.

Mr. VAN HOLLEN. Mr. Speaker, I rise in support of this legislation. The bill before us today would accomplish two very important things—provide a long-term fix to the Medicare physician reimbursement problem and implement statutory pay-as-you-go, PAYGO, rules will promote long-term fiscal responsibility for our nation.

Permanent reform of the flawed Medicare physician payment formulas is necessary to ensure that beneficiaries can see their doctor of choice and protect access to care. Consistent with the House Budget Resolution and President Obama's recommendation, this bill uses realistic and responsible assumptions about future Medicare spending on physician services. The choice is clear: We need to fix this problem honestly today and not continue to kick the can down the down the road.

As we put Medicare physician payments on a sustainable path, so must we tend to the fiscal health of our Nation. The day President Obama was sworn into office, he inherited huge deficits and exploding debt in this country. The previous administration wanted to put everything on our national credit card and ask future generations to pay for it. It is the legacy of this irresponsible spending that has left us with today's historic Federal debt.

Fortunately, there is a time-tested solution for bringing our budget back into balance: PAYGO budget rules. We have had the benefit of PAYGO in the past. For example, when the PAGYO rule was in place in the 1990s, our Federal budget went from record deficits to record surplus. In fact, when President Clinton left office, CBO projected that America would have an $800 billion surplus this year. However, when Congress abandoned PAYGO in 2002, the Federal debt exploded. Today, we are saddled with a $1.4 trillion deficit.

Digging out of this economic ditch will take time, but it is important that we put our economy on a long-term, sustainable path. PAYGO will do that by requiring policies that result in revenue reduction or increased mandatory spending be offset over the next 5 and 10 years. It will force Congress to evaluate the tradeoffs inherent in its financial decisions and make hard choices, just like any family in America.

Mr. Speaker, with this legislation, we will be putting our country on a path of fiscal responsibility. Let's tell our children and grandchildren that we're going to take some responsibility. I urge my colleagues to support this important legislation.

Mr. LANGEVIN. Mr. Speaker, I rise today in support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009. This legislation will prevent a scheduled 21 percent Medicare payment cut to physicians, while providing a long-term fix to the flawed Medicare reimbursement formula that has threatened access to care for over a decade.

Congress has made unprecedented strides this year in the fight to reform our nation's health insurance system. On November 7, I was proud to support the first comprehensive health reform bill to pass the House in several decades. This was an historic achievement, but we have more work to do. Low Medicare reimbursement rates have made it difficult to retain qualified doctors in Rhode Island, particularly those who practice primary care. This is not just a problem for Rhode Island's seniors; it is an issue that affects every patient in Rhode Island and throughout the country.

The Medicare Sustainable Growth Rate formula, or SGR, was a cost control measure instituted in 1997 that has required repeated cuts in physician reimbursements that don't reflect the true costs of care. Since 2002, Congress has recognized this fact and passed yearly fixes to prevent these cuts from taking effect. If left unresolved, this problem will result in a total reimbursement cut of 40 percent to doctors by 2016, the same time period during which we will see even more baby boomers entering the Medicare program.

H.R. 3961 replaces the pending 21 percent fee cut with an update for 2010 based on the Medicare economic index, estimated at 1.2 percent. Beginning in 2011, the update adjustment factor would be based on spending for each category of service since 2009, wiping the slate clean from the onerous accrual of cuts that have loomed over doctors for years. In addition, it provides an extra growth allowance for primary care services to promote access to primary care practitioners in Medicare and throughout the health care system.

Successful health reform must include a Medicare payment structure that ensures fair reimbursement for doctors and continued access for seniors. H.R. 3961 is a necessary step toward achieving that goal, and I urge my colleagues to support its passage.

Mr. BACA. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act.

Congress is only a few steps away from passing a healthcare reform bill and sending it to the President's desk for a signature.

However the 21% cut to physician payments under Medicare scheduled to go into effect on January 1st is just around the corner.

We must act now to protect Medicare patient's access to their doctors. We must act now to protect military and their families under TRICARE the access to their doctors. The status quo is not an option; we must not let these cuts go through. Let's stop the cuts and short-term patches once and for all; this is real reform with a real solution.

Today I will vote for the 194,510 Medicare patients in my District. Access to healthcare is not a privilege, it is a human right. I urge my colleagues vote for H.R. 3961 and preserve the access of Americans to see their doctor.

Ms. RICHARDSON. Mr. Speaker, I rise today in strong support of H.R. 3961, the ''Medicare Physician Payment Reform Act of 2009.'' Our seniors and veterans have worked for affordable, quality, and accessible health care. The bill before us, H.R. 3961, ensures that Medicare payments fairly compensate physicians for their services. This legislation will ensure that doctors will be available to treat their Medicare patients.

Over the last five years, Medicare payment rates to doctors were set artificially low just to keep the system from becoming insolvent. That was the wrong approach. Instead of saving money, the system had the unintended consequence of discouraging doctors from accepting Medicare patients. Under the ''Sustainable Growth Rate'' formula, or ''SGR,'' employed by the previous Administration and Congresses, the rate of physicians' reimbursement steadily decreased in order to restrain the growth of overall Medicare spending. So while aggregate spending was balanced, payments to individual doctors provided minimal incentive for them to continue treating Medicare patients.

Indeed, if this flawed SGR formula were implemented in its current form, Medicare physicians would suffer a 21 percent fee reduction in January 2010. This would be disastrous for Medicare patients because many of their doctors would no longer be able to afford to provide them with the quality care they need.

H.R. 3961 will allow doctors to keep their doors open to their Medicare and TRICARE patients. Rather than being reimbursed based on some externally constructed, faulty measure such as the SGR, doctors will be reimbursed based on a new measure, one that reflects the actual cost of the services they provide to their patients. H.R. 3961 also sets 2009 as the baseline for years to come. This means that, rather than a steadily declining reimbursement, doctors will experience a reimbursement rate that either matches or slightly exceeds what they received the year before. This bill ends the cycle of fee reductions based on an artificially constructed formula and replaces it with a stable system that reflects the valuable relationship between seniors and their doctors.

In my district alone, there are more than 60,000 seniors on Medicare. For them, this bill means access to the quality care provided by their doctor. Since doctors know they will be reimbursed fairly for their services, they will not feel compelled to close their doors to the Medicare and TRICARE patients in my district.

This bill also establishes more moderate target growth rates for Medicare spending. These target growth rates are much more realistic than the SGR and they will not result in the types of fee reductions like the 21 percent reduction that is currently threatening physicians. Finally, this bill encourages integrated care so that providers can communicate and develop a comprehensive wellness plan that meets the needs of each patient.

Mr. Speaker, it is not surprising that President Obama strongly supports H.R. 3961. He understands the relationship between reasonable reimbursement rates and availability of

quality care for Medicare beneficiaries. Likewise, the American Medical Association supports this bill because it provides physicians with the financial stability they need to invest in the infrastructure needed to build a health care system that works. The AARP supports this bill because it represents meaningful, sustainable reform for the 40 million seniors it represents.

I support this bill because it continues the work we began this month when we passed the historic Affordable Health Care for America Act. This necessary and timely reform benefits our seniors and our veterans. As we approach the Thanksgiving holiday, the security and peace of mind that this legislation will bring to our seniors and veterans is something for which we can all be thankful. I urge my colleagues to support H.R. 3961.

Mr. POSEY. Mr. Speaker, I rise in strong support of legislation to fix the physician fee cut. This system has been broken for more than six years and rather than fix the problem, previous Congresses have simply kicked the can down the road and now physicians are facing more than a 20 percent reduction in payments come January 1, 2010. This is unacceptable.

Stopping the cut and putting physician payments on a realistic payment formula should have been a higher priority for this Congress. Here we are, less than one month away from the January 1 deadline, and the Speaker finally decides to bring legislation to the floor for a vote. Unfortunately, the bill she has brought to the floor has many of the same shortcomings in it that S. 1776 did when the Senate rejected that bill on October 21, 2009. That bill fell 13 votes short of the number needed for passage, principally, because it was not paid for and simply added hundreds of billions of dollars to the record level national debt.

On November 7, 2009, the House passed comprehensive health care reform legislation (H.R. 3962) on a 220–215 vote. That bill creates a new unsustainable health care program that the federal government has no way to pay for long-term. Rather than making H.R. 3962 a priority, the Congress should have first considered legislation to fix the physician payment problem by replacing the inherently flawed sustainable growth rate (SGR) formula. Sadly, the majority chose the opposite path. Congress should, in my view, fix the problems with the current programs—Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)—before creating new programs that we cannot afford.

In states such as Florida, which have large numbers of seniors, the erosion of payments under Medicare has had an adverse impact on the ability of some seniors to have access to good medical providers, and it makes it difficult for Florida to attract new providers.

The only reason that this bill (H.R. 3961) has been separated out from H.R. 3962, which passed the House two weeks ago, is because Congressional leaders want to make the cost of overall comprehensive health care reform (H.R. 3962) appear less expensive.

The American people deserve better. The most appropriate approach is to end the budget games, acknowledge the realistic costs of legislation, and find the appropriate ways to pay the costs of the bill without adding further to our Nation's record debt.

Fixing the payment formula should be the top priority for the Congress at this time, not an afterthought. The good news is that there are appropriate and sufficient ways to fund the cost of averting the 21 percent payment cut. The question before Congress is whether the Leaders in Congress will switch gears and put the SGR fix at the top of the legislative agenda and use these offsets to fix what is broken with Medicare, rather than playing politics and budget games.

I will be voting for the alternative to the Speaker's bill. This alternative will increase physician payments by 2 percent in each of the next four years, enact liability reforms, and implement insurance administrative simplification reforms to cut physicians' administrative costs. Overall, this is a much better and more certain approach for physicians.

Our physicians and seniors deserve a quick fix to this problem. Let's pass a bill that has a chance in the Senate, rather than passing a bill that has the same fatal flaws as a bill they have already voted down.

Mr. THOMPSON of California. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act.

We've all heard from our constituents how important their relationship is with their doctor. We have a system that works—over 45 million people across the country depend on Medicare for that doctor-patient relationship.

Yet every year this doctor-patient relationship is threatened by excessive cuts to Medicare reimbursement rates. Every year we wait until the last minute to address it in Congress. Meanwhile, patients worry that they will lose access to their doctors. And doctors worry about how they will be able to continue to serve their patients.

This bill will permanently fix this problem—so that we don't have to put patients and their doctors through this yearly ritual, and Medicare recipients will have continuous access to their doctors. I urge my colleagues to vote yes on this legislation.

Mr. FRELINGHUYSEN. Mr. Speaker, I rise in opposition to H.R. 3961.

It goes without saying that I recognize that doctors are the backbone of Medicare and our health care system in general. As such, they must be compensated by the federal government in a manner that allows them to recover their expenses at the very least. I have been very supportive of providing doctors with a fair and equitable reimbursement for their services.

I recognize that an increasing number of physicians are finding it financially impossible to treat Medicare patients and another reduction in reimbursement levels would encourage more doctors to drop Medicare patients, endangering the health of the most vulnerable of our society—the frail elderly.

I have also been informed that nearly one-third of physicians in America are near or have actually achieved retirement age.

It would not take much in terms of lower reimbursements or additional bureaucratic red tape to encourage them to close their practices, further limiting access to quality health care for many older Americans.

I have supported Medicare fee ''fix'' legislation over the years. However, this bill is different. It is not ''paid for'' and presents another unnecessary blow to our embattled taxpayers and future generations of Americans.

Enough is enough! We have to stop spending borrowed federal dollars like there is no tomorrow!

As I stated earlier, I understand that we must prevent the Medicare physician reimbursement level from being slashed by a catastrophic 21 percent. But the $285 billion cost of this legislation can and must be offset.

I suggest that the unspent balance of the failed economic stimulus bill is a great place to start.

Mr. Speaker, I urge defeat of the bill.

Mrs. MALONEY. Mr. Speaker, I rise in strong support of H.R. 3961, the Medicare Physician Payment Reform Act, also known as the Doc Fix. I am proud to represent thousands of doctors who both live and work in New York's 14th Congressional District. Each year, I am visited by hundreds of them and hear from hundreds more, who are concerned about their patient's access to care due to a scheduled annual cut to their Medicare payments. Under the current system, when Medicare utilization of physicians' services exceeds the Sustainable Growth Rate, SGR, target, physicians are unfairly penalized with steep cuts in their payment update. With this bill, we are averting a 21-percent cut in Medicare rates while saving patient access to care by working toward a permanent fix of the SGR. After all, a stable and predictable payment system for physician service delivery is critical to preserving patient-centered care and investing in health care for the 21st century.

H.R. 3961 finally addresses the problem with the SGR formula that plagues Congress each year when we are forced to do a quick fix to prevent drastic cuts to doctor payments. This important legislation makes a critical first step toward physician payment reform by establishing distinct growth rates and spending targets. It establishes fairer growth targets to keep doctors' pay steady and erases the debt that was produced by the short-term patches that stopped cuts from going into effect over the past 7 years. At the same time, it holds physicians accountable for spending growth. H.R. 3961 promotes primary care that can keep Americans healthier longer by providing an extra growth allowance for primary care services to promote access to primary care practitioners in Medicare and throughout the health care system.

H.R. 3961 encourages integrated care to ensure our doctors are communicating with one another. When doctors speak about our care, mistakes are avoided and quality improves.

Finally, H.R. 3961 is fiscally responsible and is paid for. This bill will not increase total payments to physicians above what they are today and is paygo neutral.

The old system is broken, and this bill fixes it. With the lack of predictability in Medicare payments, older doctors with older patients retire early and younger doctors are discouraged from entering specialties that treat predominately Medicare patients. Fixing the SGR is critical to preserving Medicare patients' access to care and passage of this bill is a crucial part of health care reform. I urge my colleagues to vote in favor of this important legislation.

Mr. KUCINICH. Mr. Speaker, I rise in support of H.R. 3961, the Medicare Physician Payment Reform Act. Unfortunately, the bill includes statutory-pay-as-you-go requirements. Our country's economy continues to flounder in the worst downturn since the Great Depression, yet Congress insists on passing legislation that will constrain our ability to respond appropriately to our economic circumstances.

The Nation's unemployment rate is over 10 percent, and is likely to remain high well into the next year. The private sector is slashing payrolls and squeezing productivity out of the employees who remain, stubbornly refusing to contribute to an economic recovery. The government must be the spender of last resort to get Americans working again. While the Recovery Act has certainly helped to stave off a more severe economic downturn, it is obviously insufficient. We have more work to do, but pay-as-you-go requirements will only inhibit our ability to help our constituents.

However, Medicare is one of the most popular government programs in part because, in contrast to private insurance plans, seniors and people with certain disabilities can have access to their doctor of choice. Doctors will be less willing to participate, however, if they are not sufficiently paid, as is the case now. I have met with doctors and doctor representatives in the Cleveland area to discuss the issue and the urgency is clear. We must maintain incentives that lead to a high standard of care. I am especially supportive of the extra growth allowance for primary care services as a small down payment toward addressing a severe shortage of primary care physicians. For those reasons, I support the Medicare Physician Payment Reform Act.

Mr. ETHERIDGE. Mr. Speaker, I rise today in strong support of H.R. 3961, the Medicare Physician Payment Reform Act of 2009.

H.R. 3961 repeals the irresponsible budget gimmicks of the last decade, replacing a scheduled 21 percent fee reduction for doctors who accept Medicare with a more rational and stable system. The new payment formula will support primary care and encourage coordination among providers, while holding physicians accountable for spending growth. H.R. 3961 builds on the historic health insurance reform bill the House passed two weeks ago, which will lower premiums, extend the solvency of Medicare by 5 years, and close the ''donut hole'' drug coverage gap.

Medicare is a vital lifeline for seniors, but it is worthless if doctors cannot afford to see Medicare patients. Seniors should be able to see the doctors they prefer, and fixing the doctor payment system will make sure they have access to high-quality care from people they trust. Countless doctors in my district have told me that they are happy to treat seniors, but that they risk going out of business with current Medicare payments. We must make sure that they continue to be able to provide high-quality health care to Medicare beneficiaries.

H.R. 3961 will replace the flawed physician payment system that continually threatens access to care for our Nation's elderly and disabled patients. Since TRICARE rates are tied to Medicare, the current system also threatens the health of our military families covered by TRICARE. Fixing the system will provide physician practices with financial stability and predictability and enable them to invest in the infrastructure needed to build a health care system for the 21st century.

Without Medicare physician payment reform, the goals of health system reform will remain out of reach. Another short-term ''patch'' would only increase the severity of future cuts and raise the costs of permanently repealing the sustainable growth rate. Medicine can no longer support the sort of short-term patches that have been used in the past to postpone true payment reform. By fixing the doctor payment issue and including PAYGO, Congress is replacing the reckless borrow-and-spend policies of the last decade with responsible and reliable budget planning.

Mr. Speaker, H.R. 3961 is fiscally responsible and will improve the health and health care of people across my district, North Carolina, and the country. I urge my colleagues to join me in strong support of our seniors and the physicians who keep them healthy.

Mr. GOODLATTE. Mr. Speaker, I rise in opposition to H.R. 3961.

Under current law, Medicare physician reimbursement rates are expected to be cut by 21 percent next year and by roughly 5 percent for each of the next several years thereafter, according to the 2009 Medicare Trustees Report.

While we can all agree that our current physician reimbursement rate is flawed, Republicans and Democrats have many different ideas about how to fix it.

Since 2003, Congress has offset the cost of averting physician payment cuts. Unfortunately, today's legislation's further exacerbates the Democratic majority's infatuation with deficit spending.

According to CBO, the full cost of H.R. 3961 is $260 billion, $210 billion of which is deficit spending by the federal government. Furthermore $50 billion will be paid for by Medicare beneficiaries in the form of higher Part B premiums.

The Democrats' health care takeover already costs over $1 trillion. In order to hide the additional costs of that bill, the Democrats separated this physician reimbursement rate legislation from the larger health care bill.

It is clear that this procedural move is simply a budget gimmick by Democrats to avoid including the full cost of this Medicare physician fix in their health care reform bill. This trickery is insulting to Americans who are tired of politics as usual and who are demanding straight answers about our nation's deteriorating fiscal situation.

This legislation also breaks President Obama's promise that health care reform would not cost more than $900 billion. Taking CBO's 10-year score of the health care overhaul, $1.055 trillion, and adding the cost of this physician reimbursement fix, the total cost of the Democrats' health care reform would be at least $1.3 trillion.

Mr. Speaker, I cannot support the deficit spending in this legislation. As I stated previously, according to the Congressional Budget Office, CBO, this bill would increase the Federal deficit by more than $210 billion with this one bill alone.

The American people know that we can't borrow and spend our way back to prosperity. The path to our economic recovery starts with fiscal responsibility in Washington. The Federal Government must follow the example set by our Nation's families.

Unfortunately, Democrats continue to ignore this reality. We have accumulated a 2009 deficit of $1.42 trillion and a national debt of over $12 trillion and Democrats seem determined to dig us deeper into this debt hole.

While my colleagues on the other side of the aisle may have concocted a scheme to enable this bill to pass today, I hope they realize that the Senate has already rejected a bill substantially similar to this one, almost identical in cost, because of its crippling deficit impact. In fact, 13 Democrat Senators opposed it.

Mr. Speaker, the Rules Committee is a very powerful committee—one that determines under what rules every bill will be brought to the House floor. In yet another strong-armed tactic, the majority has used yet another rule to limit discussion and amendments offered by Republicans. Instead of having an honest debate, the Democratic majority has decided they didn't like the discussion, so they have effectively decided to stifle alternative ideas and debate. This doesn't seem very democratic to me.

House Republicans have a better alternative. Our proposal, which was not given the light of day, much less a vote, would provide: $54 billion in savings from medical liability reform that would enact caps on noneconomic damages and lawyers' fees, encouraging speedy resolutions of claims, and limit punitive damages. This will reduce defensive medicine, protect doctors from frivolous lawsuits, and bring down the cost of health care; $5.7 billion in savings from the creation of a pathway for approval at the Food and Drug Administration for bio-similar products, with appropriate protections that continue to promote innovation while providing access to affordable drugs; and $19 billion in savings through enacting health insurance administrative simplification policies such as the creation of standardized forms and transactions.

Mr. Speaker, there is a fiscally responsible way to solve this physician reimbursement problem. I urge my colleagues to oppose H.R. 3961.

Mr. TIAHRT. Mr. Speaker, I rise today in reluctant opposition to H.R. 3961. I say reluctant because we desperately need a real physician reimbursement rate fix. The future of medicine and the health of Americans, especially seniors, depends on a cost-based formula to reimburse providers for medical expenses. This bill, however, is not a real fix but yet another political and budget gimmick.

The issue known as the ''doctor fix'' is familiar to us all, but I don't think that the majority fully understands who suffers under inadequate physician pay—the American people. CMS reimbursement rates to providers is anywhere from 30–70 percent of actual cost, based on the specific procedure. Even the highest CMS reimbursement is still loss to providers. It isn't just the doctors who suffer but also the patients. Many doctors have to close their door to new Medicare and Medicaid patients or face bankruptcy. This is especially troubling in rural areas where there are limited providers and seniors face a serious medical accessibility problem. In Kansas, between 20–30 percent of physicians say they will no longer accept new Medicare patients. These doctors, especially in rural areas, go into their profession to help people and having to turn away patients is a measure of absolute last resort.

The current formula for physician reimbursement is known as the sustainable growth rate, SGR, and has little if anything to do with actual costs. That is why year after year Congress passes adjustments to prevent cuts in reimbursement rate. These adjustments are the bare minimum that we can do, even staving off cuts for one year does not allow for certainty in the system.

For that reason, for years several of us have been trying to get CMS to get rid of the SGR and instead base reimbursement rates on actual medical costs. I brought data to

then-Chairman Bill Thomas showing that more and more Kansas doctors were refusing new Medicare patients. Due to the overwhelming evidence that this is a real problem, the House version of the Medicare Modernization Act, the prescription drug bill, included language directing CMS to scrap the SGR and come up with a real reimbursement rate formula. Unfortunately, the Senate stripped that provision and subsequent efforts to enact real SGR reform have failed.

H.R. 3961 is not real SGR reform, but rather putting lipstick on a pig. As the Association of American Physicians and Surgeons asserts, ''It just trades one complicated federal formula for another, and still leaves physician pay subject to Congressional whim in the future.'' The Democrat proposal uses GDP and other factors instead of actual cost to calculate reimbursement rates and does nothing to prevent the need for further congressional 1-year adjustments to the rate.

The Democrat health care proposals, including H.R. 3961, do nothing to address the rising cost of health care, and indeed will cause costs to rise faster than they do today. There are several things we need to do to improve access to and quality of health care, including addressing physician reimbursement rates. Real health reform requires addressing the cost centers that are driving insurance costs up, reducing provider services, and discouraging professionals from entering medicine. For this reason, a recent IB/TIPP Poll revealed that two-thirds of physicians oppose the Democrat bills, and furthermore warn of dire consequences should they be enacted. In addition, 45 percent of physicians said that they would consider leaving their practice or take early retirement.

I am hopeful that the Democrat leadership will abandon this political gimmick and work with us to address physician reimbursement rates. This is no ''Chicken Little'' story. Without congressional action, the sky will fall in, doctors will be unable to participate in Medicare and our seniors will be left without care—regardless of Obamacare reforms.

Ms. ESHOO. Mr. Speaker, I rise today in support of H.R. 3961, the Medicare Physician Payment Reform Act.

H.R. 3961 would repeal the current Medicare Sustainable Growth Rate, SGR, formula and save our physicians from a looming 21 percent reimbursement cut. Instead of temporarily overriding the cut as Congress has done before, H.R. 3961 will replace the broken SGR formula with a sustainable solution.

This bill is essential, not only for the doctors who deserve adequate reimbursement for services, but for the millions of Medicare beneficiaries and members of the military and their families, since physician payment rates in TRICARE are tied to those used by Medicare. With comprehensive healthcare reform on the horizon, it's our responsibility to ensure physicians are reimbursed appropriately.

H.R. 3961 is supported by a wide range of organizations representing patients, doctors and other providers, including the American Medical Association, AARP, the Military Officers Association of America, the American Academy of Family Physicians, the American College of Physicians, the American College of Surgeons, the Center for Medicare Advocacy, the Medicare Rights Center, and the National Committee to Preserve Social Security and Medicare.

This is critically needed and sound legislation and I look forward to voting in favor of H.R. 3961 and ask my colleagues to do the same.

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

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 903, the previous question is ordered on the bill.

MOTION TO RECOMMIT OFFERED BY MR. GINGREY OF GEORGIA

Mr. GINGREY of Georgia. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. GINGREY of Georgia. In its present form, I am.

Mr. WAXMAN. Mr. Speaker, I reserve a point of order.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Gingrey of Georgia moves to recommit the bill, H.R. 3961, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare SGR Improvement and Reform Act of 2009''.

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

TITLE I—ENSURING CONTINUED ACCESS TO PHYSICIANS IN MEDICARE

SEC. 101. IMPROVING MEDICARE PHYSICIAN PAYMENTS.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraphs:

''(10) 2 PERCENT ANNUAL UPDATE FOR YEARS 2010 THROUGH 2013.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B) and subparagraph (B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for each of 2010, 2011, 2012, and 2013, the update to the single conversion factor shall be 2 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2014 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2014 and subsequent years as if subparagraph (A) had never applied, subject to paragraph (11).

''(11) UPDATE FOR 2014 AND POSSIBLE SUBSEQUENT YEARS THROUGH 2019.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B) and subparagraph (B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014 and, at the Secretary's discretion, for subsequent years ending not later than 2019, the update to the single conversion factor shall be such percentage for each such year as the Secretary determines will result in additional expenditures under this title in the aggregate for all such years of $26,400,000,000. Not later than October 1, 2013, the Secretary shall establish by regulation the method the Secretary will use in allocating the $26,400,000,000 under the previous sentence between 2014 and subsequent years. Such allocation shall be designed in a manner so that the single conversion factor for a year is not less than 79 percent of the conversion factor for the previous year.

''(B) LIMITED EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for subsequent years as if subparagraph (A) had never applied, but taking into account the aggregate additional increase in expenditures permitted under such subparagraph.''.

SEC. 102. STATEMENT OF POLICY.

It is the policy of the Federal Government that the sustainable growth rate formula, upon which physician payments are based for the Medicare program, should be permanently repealed and replaced with a reimbursement policy that pays doctors an amount reflecting the true cost of services provided in a high-quality and efficient manner and uses a fiscally responsibly funding mechanism.

TITLE II—DEFICIT PROTECTION AND FISCAL RESPONSIBILITY

Subtitle A—Enacting Real Medical Liability Reform

SEC. 201. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 202. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 203. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 204. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 205. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

SEC. 206. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 207. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience,

physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term ''compensatory damages'' includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 208. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 209. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this subtitle (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This subtitle shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this subtitle or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this subtitle shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 202(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 210. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Application of Medicare Improvement Fund

SEC. 211. APPLICATION OF MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''for services furnished'' and all that follows and inserting ''for services furnished on or after January 1, 2010, $0.''.

Subtitle C—Pathway for Biosimilar Biological Products

SEC. 221. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

''(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

''(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations);

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(5).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) PEDIATRIC STUDIES.—

''(A) EXCLUSIVITY.—If, before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant or holder of the approved application agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and

the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act the period referred to in paragraph (7)(A) of this subsection is deemed to be 12 years and 6 months rather than 12 years.

''(B) EXCEPTION.—The Secretary shall not extend the period referred to in subparagraph (A) of this paragraph if the determination under section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act is made later than 9 months prior to the expiration of such period.

''(C) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (h), (j), (k), and (l) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under subparagraph (A) of this paragraph to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(9) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

''(l) PATENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

''(1) DEFINITIONS.—For the purposes of this subsection, the term—

''(A) 'biosimilar product' means the biological product that is the subject of the application under subsection (k);

''(B) 'relevant patent' means a patent that—

''(i) expires after the date specified in subsection (k)(7)(A) that applies to the reference product; and

''(ii) could reasonably be asserted against the applicant due to the unauthorized making, use, sale, or offer for sale within the United States, or the importation into the United States of the biosimilar product, or materials used in the manufacture of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application;

''(C) 'reference product sponsor' means the holder of an approved application or license for the reference product; and

''(D) 'interested third party' means a person other than the reference product sponsor that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

''(2) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until the individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

''(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

''(A) the reference product identified in the application; and

''(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

''(4) EXCHANGES CONCERNING PATENTS.—

''(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

''(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

''(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference product sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise has an interest in the patent as such patent concerns the biosimilar product.

''(iii) If the reference product sponsor is issued or acquires an interest in a relevant patent after the date on which the reference product sponsor provides the list required by clause (ii) to the applicant, the reference product sponsor shall identify that patent to the applicant within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

''(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

''(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

''(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

''(iv) If the interested third party is issued or acquires an interest in a relevant patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

''(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

''(i) shall explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, or importation into the United States, of the biosimilar product or by a use of the biosimilar product in treatment that is indicated in the application;

''(ii) may specify whether the relevant patent is available for licensing; and

''(iii) shall specify the number and date of expiration of the relevant patent.

''(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (iii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

''(i) state that the applicant will not commence marketing of the biosimilar product and has requested the Secretary to not grant final approval of the application before the date of expiration of the noticed patent; or

''(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

''(I) the making, use, sale, or offer for sale within the United States, or the importation into the United States, of the biosimilar product, or the use of the biosimilar product

in a treatment indicated in the application, would not infringe the patent; or

''(II) the patent is invalid or unenforceable.

''(5) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent identified by the reference product sponsor under clause (ii) or (iii) of paragraph (4)(A), or by an interested third party under clause (iii) or (iv) of paragraph (4)(B), is brought within 60 days of the date of receipt of a statement under paragraph (4)(D)(ii), and the court in which such action has been commenced determines the patent is infringed prior to the date applicable under subsection (k)(7)(A) or (k)(8), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

''(6) NOTIFICATION OF AGREEMENTS.—

''(A) REQUIREMENTS.—

''(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

''(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products with the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

''(B) SUBJECT MATTER OF AGREEMENT.—An agreement described in this subparagraph—

''(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of—

''(I) the biosimilar product (or biosimilar products) for which an application was submitted; or

''(II) the reference product;

''(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i); and

''(iii) excludes any agreement that solely concerns—

''(I) purchase orders for raw material supplies;

''(II) equipment and facility contracts;

''(III) employment or consulting contracts; or

''(IV) packaging and labeling contracts.

''(C) FILING.—

''(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than—

''(I) 10 business days after the date on which the agreement is executed; and

''(II) prior to the date of the first commercial marketing of, for agreements described in subparagraph (A)(i), the biosimilar product that is the subject of the application or, for agreements described in subparagraph (A)(ii), any biosimilar product that is the subject of an application described in such subparagraph.

''(ii) IF AGREEMENT NOT REDUCED TO TEXT.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms and conditions of the agreement.

''(iii) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the following is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(l)(6) of the Public Health Service Act, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'.

''(D) DISCLOSURE EXEMPTION.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph prevents disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

''(E) ENFORCEMENT.—

''(i) CIVIL PENALTY.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action—

''(I) brought by the United States; or

''(II) brought by the Federal Trade Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act.

''(ii) COMPLIANCE AND EQUITABLE RELIEF.—If any person violates any provision of this paragraph, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Federal Trade Commission.

''(F) RULEMAKING.—The Federal Trade Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this paragraph—

''(i) may define the terms used in this paragraph;

''(ii) may exempt classes of persons or agreements from the requirements of this paragraph; and

''(iii) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this paragraph.

''(G) SAVINGS CLAUSE.—Any action taken by the Assistant Attorney General or the Federal Trade Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this paragraph shall not at any time bar any proceeding or any action with respect to any agreement between a biosimilar product applicant under subsection (k) and the reference product sponsor, or any agreement between biosimilar product applicants under subsection (k), under any other provision of law, nor shall any filing under this paragraph constitute or create a presumption of any violation of any competition laws.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section

351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

SEC. 222. FEES RELATING TO BIOSIMILAR BIOLOGICAL PRODUCTS.

Subparagraph (B) of section 735(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)) is amended by inserting '', including licensure of a biological product under section 351(k) of such Act'' before the period at the end.

SEC. 223. AMENDMENTS TO CERTAIN PATENT PROVISIONS.

(a) Section 271(e)(2) of title 35, United States Code is amended—

(1) in subparagraph (A), by striking ''or'' after ''patent,'';

(2) in subparagraph (B), by adding ''or'' after the comma at the end;

(3) by inserting the following after subparagraph (B):

''(C) a statement under section 351(l)(4)(D)(ii) of the Public Health Service Act,''; and

(4) in the matter following subparagraph (C) (as added by paragraph (3)), by inserting before the period the following: '', or if the statement described in subparagraph (C) is provided in connection with an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of which is claimed in a patent before the expiration of such patent''.

(b) Section 271(e)(4) of title 35, United States Code, is amended by striking ''in paragraph (2)'' in both places it appears and inserting ''in paragraph (2)(A) or (2)(B)''.

Subtitle D—Administrative Simplification

SEC. 231. ADMINISTRATIVE SIMPLIFICATION.

(a) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new subparagraph:

''(J) Electronic funds transfers.''; and

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

''(g) OPERATING RULES.—

''(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction described in subsection (a)(2) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

''(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall rely on recommendations for operating rules developed by a qualified nonprofit entity, as selected by the Secretary, that meets the following requirements:

''(A) The entity focuses its mission on administrative simplification.

''(B) The entity demonstrates an established multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

''(C) The entity has established a public set of guiding principles that ensure the operating rules and process are open and transparent.

''(D) The entity coordinates its activities with the HIT Policy Committee and the HIT Standards Committee (as established under title XXX of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

''(E) The entity incorporates national standards, including the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

''(F) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

''(G) The entity allows for public review and updates of the operating rules.

''(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

''(A) review the operating rules developed by a nonprofit entity described under paragraph (2);

''(B) determine whether such rules represent a consensus view of the health care industry and are consistent with and do not alter current standards;

''(C) evaluate whether such rules are consistent with electronic standards adopted for health information technology; and

''(D) submit to the Secretary a recommendation as to whether the Secretary should adopt such rules.

''(4) IMPLEMENTATION.—

''(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health Statistics under paragraph (3)(D) and having ensured consultation with providers.

''(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

''(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for transactions for eligibility for a health plan and health claim status shall be adopted not later than July 1, 2011, in a manner ensuring that such rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

''(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice shall be adopted not later than July 1, 2012, in a manner ensuring that such rules are effective not later than January 1, 2014.

''(iii) OTHER COMPLETED TRANSACTIONS.—The set of operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, shall be adopted not later than July 1, 2014, in a manner ensuring that such rules are effective not later than January 1, 2016.

''(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept public comments on any interim final rule published under this subparagraph for 60 days after the date of such publication.

''(h) COMPLIANCE.—

''(1) HEALTH PLAN CERTIFICATION.—

''(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

''(B) OTHER COMPLETED TRANSACTIONS.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, respectively. A health plan shall provide the same level of documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

''(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

''(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

''(B) provides documentation showing that the plan has completed end-to-end testing for such transactions with their partners, such as hospitals and physicians.

''(3) SERVICE CONTRACTS.—A health plan shall be required to comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under this subsection for any entities that provide services pursuant to a contract with such health plan.

''(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may contract with an independent, outside entity to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or rules issued by the Secretary.

''(5) COMPLIANCE WITH REVISED STANDARDS AND RULES.—A health plan (including entities described under paragraph (3)) shall comply with the certification and documentation requirements under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that amends any standard or operating rule described under paragraph (1) of this subsection. A health plan shall comply with such requirements not later than the effective date of the applicable interim final rule.

''(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1).

''(i) REVIEW AND AMENDMENT OF STANDARDS AND RULES.—

''(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

''(2) EVALUATIONS AND REPORTS.—

''(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the existing standards and operating rules established under this section.

''(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

''(3) INTERIM FINAL RULEMAKING.—

''(A) IN GENERAL.—Any recommendations to amend existing standards and operating rules that have been approved by the review committee and reported to the Secretary under paragraph (2)(B) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee's report.

''(B) PUBLIC COMMENT.—

''(i) PUBLIC COMMENT PERIOD.—The Secretary shall accept public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

''(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

''(4) REVIEW COMMITTEE.—

''(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

''(i) the National Committee on Vital and Health Statistics; or

''(ii) any appropriate committee as determined by the Secretary.

''(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall consider the standards approved by the Office of the National Coordinator for Health Information Technology.

''(j) PENALTIES.—

''(1) PENALTY FEE.—

''(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subparagraph (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with the standards (and their operating rules) as described under paragraph (1) of such subsection.

''(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

''(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under this subsection.

''(D) ANNUAL FEE INCREASE.—The amount of the penalty fee imposed under this subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

''(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

''(i) an amount equal to $20 per covered life under such plan; or

''(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (as described under subparagraph (C)).

''(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

''(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and a dispute resolution procedure prior to provision of a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

''(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

''(4) COLLECTION OF PENALTY FEE.—

''(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, shall administer the collection of penalty fees from health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3).

''(B) NOTICE.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection. Such notice shall include the amount of the penalty fee assessed by the Secretary and the due date for payment of such fee to the Secretary of the Treasury (as described in subparagraph (C)).

''(C) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

''(D) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

''(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6601 of the Internal Revenue Code of 1986; and

''(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6402(d) of the Internal Revenue Code of 1986.

''(E) ADMINISTRATIVE FEES.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.''.

(b) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee of Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (a)(2)(A)). The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(c) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

(d) MEDICARE AND MEDICAID COMPLIANCE REPORTS.—Not later than July 1, 2013, the Secretary of Health and Human Services shall submit a report to the Chairs and Ranking Members of the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Chairs and Ranking Members of the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate on the extent to which the Medicare program and providers that serve beneficiaries under that program, and State Medicaid programs and providers that serve beneficiaries under those programs, transact electronically in accordance with transaction standards issued under the Health Insurance Portability and Accountability Act of 1996, part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

Mr. GINGREY of Georgia (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

Mr. WAXMAN. I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will read.

The Clerk continued to read the motion to recommit.

Mr. WAXMAN (during the reading). Mr. Speaker, I ask unanimous consent that we dispense with the reading.

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

There was no objection.

POINT OF ORDER

Mr. WAXMAN. Mr. Speaker, pursuant to clause 7 of House rule XVI, matters within the motion to recommit are not germane to the underlying bill, and I insist on my point of order.

The SPEAKER pro tempore. Does any other Member wish to be heard on the point of order?

PARLIAMENTARY INQUIRY

Mr. GINGREY of Georgia. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. GINGREY of Georgia. Mr. Speaker, the gentleman from California reserved a point of order. Does that not allow me the opportunity to speak to the point of order?

The SPEAKER pro tempore. The Chair will hear the gentleman on the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, I rise today as an OB/GYN physician who knows very well the challenges that our doctors face with the current SGR system. I can say with 100 percent confidence as a physician Member of Congress that this bill, H.R. 3961, is a bad deal. It's a bad deal for doctors, it's a bad deal for patients, and it's a bad deal for the American people upon whom this majority seems content to simply pile another $210 billion worth of debt.

Mr. WAXMAN. Mr. Speaker, I don't believe the gentleman's argument is pertinent to the point of order. I insist on my point of order.

The SPEAKER pro tempore. The gentleman from Georgia must confine his remarks to the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, during his meeting earlier this week with Chinese President Hu Jintao, I hope that President Obama asked for that $210 billion, because that's how the majority plans to pay for this bill, by borrowing more money from the Chinese.

The SPEAKER pro tempore. The gentleman must confine his remarks to the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, I will proceed.

To make matters worse, and contrary to the assertions of this majority, this bill does not fix our physician reimbursement problem, but it simply replaces one flawed system for another.

So, Mr. Speaker, my motion to recommit ensures that physicians are reimbursed fairly and that this reimbursement is fully paid for and would add not one cent to the deficit.

The SPEAKER pro tempore. The Chair will remind the Member to confine his remarks to the point of order.

Mr. GINGREY of Georgia. Allow me to explain, Mr. Speaker.

This motion to recommit will provide physicians with a 2 percent Medicare payment rate increase in each of the next 4 years. The motion to recommit would erase the scheduled 21 percent cut in 2010——

Mr. WAXMAN. Mr. Speaker, I insist on my point of order.

The SPEAKER pro tempore. The Chair will remind the Member to confine his remarks to the point of order.

The Chair is prepared to rule.

Mr. GINGREY of Georgia. Mr. Speaker, am I allowed to continue?

The SPEAKER pro tempore. The gentleman may continue on the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, the motion to recommit would erase the scheduled 21 percent cut in 2010 and the estimated 5 percent cuts in 2011, 2012, and 2013. The Democratic bill would only provide eight-tenths of 1 percent payment rate increase.

The SPEAKER pro tempore. The gentleman must confine his remarks to the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, in this underlying bill, we actually pay for our plan by enacting legislation that will not only achieve savings, but will also——

The SPEAKER pro tempore. The Chair reminds the gentleman that he must confine his remarks to the point of order.

The Chair is prepared to rule.

The gentleman from Georgia may proceed on the point of order.

Mr. GINGREY of Georgia. Mr. Speaker, on the point of order, I would like to say that unlike the underlying bill, we actually pay for our plan by enacting legislation that will not only achieve savings, but it will also improve——

The SPEAKER pro tempore. The gentleman must confine his remarks to the point of order.

The Chair is ready to rule.

Mr. GINGREY of Georgia. Mr. Speaker, I'm trying to confine my remarks to the point of order.

The SPEAKER pro tempore. The gentleman must address why the amendment is germane.

Mr. GINGREY of Georgia. In doing so, I say we simply prefer to pay for what we do without raising taxes.

The SPEAKER pro tempore. The Chair will rule.

The gentleman from California makes a point of order that the amendment proposed in the instructions included in the motion to recommit offered by the gentleman from Georgia is not germane.

The bill, H.R. 3961, addresses the narrow topic of payments under the Medicare sustainable growth rate system. The bill adjusts the formulas for the SGR system to alter payments to physicians under that system.

Among other topics, the motion to recommit addresses the subject of medical liability reform. It includes provisions on compensation, court procedure, and liability for damages.

As recorded in section 934 of the House Rules and Manual, a general principle of germaneness is that an amendment must confine itself to the committee of jurisdiction over the subject matters contained in the bill. The bill, H.R. 3961, merited referral only to the Committee on Energy and Commerce and the Committee on Ways and Means. The motion to recommit, addressing the subject of medical liability reform, introduces subject matter properly within the jurisdiction of the Committee on the Judiciary.

The motion is therefore not germane and the point of order is sustained.

Mr. GINGREY of Georgia. Mr. Speaker, I appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is, Shall the decision of the Chair stand as the judgment of the House?

Mr. WAXMAN. Mr. Speaker, I move to table the appeal of the ruling of the Chair.

The SPEAKER pro tempore. The question is on the motion to table.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GINGREY of Georgia. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to table will be followed by 5-minute votes on passage of the bill, if arising without further proceedings in recommittal, and the motion to suspend the rules on H.R. 1834.

The vote was taken by electronic device, and there were—yeas 251, nays 177, not voting 6, as follows:

[Roll No. 907]

YEAS—251

Abercrombie	Doyle	Kucinich
Ackerman	Driehaus	Langevin
Adler (NJ)	Edwards (MD)	Larsen (WA)
Altmire	Edwards (TX)	Larson (CT)
Andrews	Ellison	Lee (CA)
Arcuri	Ellsworth	Levin
Baca	Engel	Lewis (GA)
Baird	Eshoo	Lipinski
Baldwin	Etheridge	Loebsack
Barrow	Farr	Lofgren, Zoe
Bean	Fattah	Lowey
Becerra	Filner	Luján
Berkley	Foster	Lynch
Berman	Frank (MA)	Maffei
Berry	Fudge	Maloney
Bishop (GA)	Garamendi	Markey (CO)
Bishop (NY)	Giffords	Markey (MA)
Blumenauer	Gonzalez	Marshall
Boccieri	Gordon (TN)	Massa
Boren	Grayson	Matheson
Boswell	Green, Al	Matsui
Boucher	Green, Gene	McCarthy (NY)
Boyd	Griffith	McCollum
Brady (PA)	Grijalva	McDermott
Braley (IA)	Gutierrez	McGovern
Brown, Corrine	Hall (NY)	McIntyre
Butterfield	Halvorson	McMahon
Capps	Hare	McNerney
Capuano	Harman	Meek (FL)
Cardoza	Hastings (FL)	Meeks (NY)
Carnahan	Heinrich	Michaud
Carson (IN)	Herseth Sandlin	Miller (NC)
Castor (FL)	Higgins	Mitchell
Chandler	Hill	Mollohan
Childers	Himes	Moore (KS)
Chu	Hinchey	Moore (WI)
Clarke	Hinojosa	Moran (VA)
Clay	Hirono	Murphy (CT)
Cleaver	Hodes	Murphy (NY)
Clyburn	Holden	Murphy, Patrick
Cohen	Holt	Murtha
Connolly (VA)	Honda	Nadler (NY)
Conyers	Hoyer	Napolitano
Cooper	Inslee	Neal (MA)
Costa	Israel	Nye
Costello	Jackson (IL)	Oberstar
Courtney	Jackson-Lee (TX)	Obey
Crowley	Johnson (GA)	Olver
Cuellar	Johnson, E. B.	Ortiz
Cummings	Kagen	Owens
Dahlkemper	Kanjorski	Pallone
Davis (AL)	Kaptur	Pascrell
Davis (CA)	Kennedy	Pastor (AZ)
Davis (IL)	Kildee	Payne
Davis (TN)	Kilpatrick (MI)	Perlmutter
DeFazio	Kilroy	Perriello
DeGette	Kind	Peters
Delahunt	Kirkpatrick (AZ)	Peterson
DeLauro	Kissell	Pingree (ME)
Dicks	Klein (FL)	Polis (CO)
Dingell	Kosmas	Pomeroy
Doggett	Kratovil	Price (NC)
Donnelly (IN)		Quigley

Rahall	Scott (VA)	Tierney
Rangel	Serrano	Titus
Reyes	Sestak	Tonko
Richardson	Shea-Porter	Towns
Rodriguez	Sherman	Tsongas
Ross	Shuler	Van Hollen
Rothman (NJ)	Sires	Velázquez
Roybal-Allard	Skelton	Visclosky
Ruppersberger	Slaughter	Walz
Rush	Smith (WA)	Wasserman Schultz
Ryan (OH)	Snyder	Waters
Salazar	Space	Watson
Sánchez, Linda T.	Speier	Watt
Sanchez, Loretta	Spratt	Waxman
Sarbanes	Stark	Weiner
Schakowsky	Stupak	Welch
Schauer	Sutton	Wilson (OH)
Schiff	Tanner	Woolsey
Schrader	Taylor	Wu
Schwartz	Teague	Yarmuth
Scott (GA)	Thompson (CA)	
	Thompson (MS)	

NAYS—177

Aderholt	Franks (AZ)	Moran (KS)
Akin	Frelinghuysen	Murphy, Tim
Alexander	Gallegly	Myrick
Austria	Garrett (NJ)	Neugebauer
Bachmann	Gerlach	Nunes
Bachus	Gingrey (GA)	Olson
Barrett (SC)	Gohmert	Paul
Bartlett	Goodlatte	Paulsen
Barton (TX)	Granger	Pence
Biggert	Graves	Petri
Bilbray	Guthrie	Pitts
Bilirakis	Hall (TX)	Platts
Bishop (UT)	Harper	Poe (TX)
Blackburn	Hastings (WA)	Posey
Blunt	Heller	Price (GA)
Boehner	Hensarling	Putnam
Bonner	Herger	Radanovich
Bono Mack	Hoekstra	Rehberg
Boozman	Hunter	Reichert
Boustany	Inglis	Roe (TN)
Brady (TX)	Issa	Rogers (AL)
Bright	Jenkins	Rogers (KY)
Broun (GA)	Johnson (IL)	Rogers (MI)
Brown-Waite, Ginny	Johnson, Sam	Rohrabacher
	Jones	Rooney
Buchanan	Jordan (OH)	Ros-Lehtinen
Burgess	King (IA)	Roskam
Burton (IN)	King (NY)	Royce
Buyer	Kingston	Ryan (WI)
Calvert	Kirk	Scalise
Camp	Kline (MN)	Schmidt
Campbell	Lamborn	Schock
Cantor	Lance	Sensenbrenner
Cao	Latham	Sessions
Capito	LaTourette	Shadegg
Carney	Latta	Shimkus
Cassidy	Lee (NY)	Shuster
Castle	Lewis (CA)	Simpson
Chaffetz	Linder	Smith (NE)
Coble	LoBiondo	Smith (NJ)
Coffman (CO)	Lucas	Smith (TX)
Cole	Luetkemeyer	Souder
Conaway	Lummis	Stearns
Crenshaw	Lungren, Daniel E.	Sullivan
Culberson		Terry
Davis (KY)	Mack	Thompson (PA)
Deal (GA)	Manzullo	Thornberry
Dent	Marchant	Tiahrt
Diaz-Balart, L.	McCarthy (CA)	Tiberi
Diaz-Balart, M.	McClintock	Turner
Dreier	McCotter	Upton
Duncan	McHenry	Walden
Ehlers	McKeon	Wamp
Emerson	McMorris Rodgers	Westmoreland
Fallin		Whitfield
Flake	Mica	Wilson (SC)
Fleming	Miller (FL)	Wittman
Forbes	Miller (MI)	Wolf
Fortenberry	Miller, Gary	Young (AK)
Foxx	Minnick	Young (FL)

NOT VOTING—6

Brown (SC)	McCaul	Miller, George
Carter	Melancon	Wexler

□ 1553

Messrs. SESSIONS, LUETKEMEYER, WALDEN, CARNEY and GERLACH changed their vote from ''yea'' to ''nay.''

Mr. WILSON of Ohio, Ms. KILPATRICK of Michigan, Messrs. ELLISON, RODRIGUEZ, JOHNSON of Georgia and Ms. MCCOLLUM changed their vote from ''nay'' to ''yea.''

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

MOTION TO RECOMMIT

Mr. CANTOR. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill.

Mr. CANTOR. In its current form, I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Cantor moves to recommit the bill, H.R. 3961, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Add at the end of the bill the following:

SEC. 3. FINDINGS.

Congress finds that the Secretary of Health and Human Services has the authority to increase payments for services under section 1848 of the Social Security Act (related to payments for physician services) in an amount not to exceed $22,300,000,000.

SEC. 4. LIMITATIONS.

(a) IN GENERAL.—In executing the amendments made by section 2(b) of this Act the Secretary of Health and Human Services shall implement an adjustment in payments under section 1848 of the Social Security Act under such amendments for 2011 or any subsequent year only to the extent that the Secretary determines that the cost of such adjustment when added to the cost of the amendment made by section 2(a) does not exceed $22,300,000,000. Such cost determinations shall be calculated based on the difference between net expenditures resulting from the provisions of this Act and anticipated net expenditures for each year under the law as in effect before the date of the enactment of this Act.

(b) CONTINGENCY.—If the Secretary is prevented from implementing an adjustment described in subsection (a) as a result of such subsection, the Secretary shall implement section 1848 of the Social Security Act as such section was in effect before the date of the enactment of this Act.

Mr. WAXMAN (during the reading). Mr. Speaker, I ask unanimous consent to dispense with the reading.

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

There was no objection.

The Chair recognizes the gentleman from Virginia for 5 minutes in support of his motion.

Mr. CANTOR. Thank you. Mr. Speaker, we have tried to do everything possible to pay for this doctor fix, and it seems that the majority just refuses to do the fiscally responsible thing. We just offered a proposal that was a fully paid doctor fix that provided our doctors with 2 percent updates for 4 years. The majority blocked this House from even voting on that proposal because they object to paying for the costs of the doctor fix.

It seems that the rules that the majority is using prevent us from paying for this bill simply because, Mr. Speaker, the majority doesn't pay for this bill. Seeing that that is the case, one has to ask how perverse is that? Because the majority is okay with adding $250 billion to our debt, the Republicans are prevented under the rules from trying to be responsible and pay for those costs. Is this what passes for fiscal responsibility in the majority party, I ask?

So now we are offering a second motion to recommit that attempts to address the deficit costs while living under the rules imposed on us by the majority. What does this motion do? Very simply, it recognizes that there is a fund already in existing law that has $22.3 billion in it that can be used to pay for the doctor fix. It further limits spending under this bill to that same amount, $22.3 billion. That is enough to provide the doctor payment updates for all of 2010 and most, if not all, of 2011 envisioned under the Democratic bill.

So we've identified, Mr. Speaker, an amount of money that is available to pay for 2 years' worth of a doctor fix and limited this bill to 2 years. A vote for this motion to recommit is a vote to recognize that we ought to help our doctors, but we ought to do it in a fiscally responsible manner, and this motion shows us how to do it. I wish we could do more, but the rules imposed on us by the majority simply won't permit it.

So now is the time to choose: Do we want to plan for a fiscally responsible doctor fix or $250 billion in new debt? Mr. Speaker, I ask this House to vote for fiscal responsibility.

I yield to the gentleman from Georgia, Dr. PRICE.

Mr. PRICE of Georgia. Thank you. As a physician, I know that the SGR, the sustainable growth rate, is neither sustainable nor growing. It is, however, truly destroying the ability of doctors to provide the needed care for patients across our land. And though the underlying bill is an acknowledgement that there is a huge problem and may be a step in the right direction, it exacerbates the phenomenal fiscal recklessness of this administration and the majority party.

As a physician, I know with every fiber of my being that the doctors of this land are sick and tired of being played for fools, duped into support of another nonsolution because there is not a commitment to a responsible revenue stream with a recognition of the care that they provide.

□ 1600

With this trick, the majority demeans our Nation's caring and compassionate physicians. So let's commit to solve this challenge together, positively, with a plan that respects those who have dedicated their lives to our health.

Mr. Speaker, our Nation is at a fiscal tipping point. We can continue to march further and further to the liberal left and bankrupt our Nation's future, or we can restore fiscal sanity to an overgrown and unrestrained Federal budget. Our motion to recommit is a

step in the right direction, not another plan that further adds to our Nation's debt and contributes to the financial ruin of future generations.

Mr. Speaker, the American people are demanding a stop to runaway debt. They reject this spending and they reject this trick. Let's stand up for fiscal responsibility and vote for the responsible Republican solution.

Mr. CANTOR. Mr. Speaker, I yield back the balance of my time.

Mr. WAXMAN. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from California is recognized for 5 minutes.

Mr. WAXMAN. Mr. Speaker and my colleagues, this motion to recommit proposes to spend $22.3 billion for a $210 billion problem. It simply postpones the problem. It is the same old kicking the can down the road. There are no guarantees of cuts when this money runs out. The gentleman from Virginia says his proposal would mean no cuts for 2 years. I am not convinced of that 2-year period. But whatever period of time it would allow for, there would be another cliff, and that is why the American Medical Association wrote to the Honorable DAVE CAMP, ranking member of the Ways and Means Committee, that they oppose anything short of permanent reform. They want us to deal with this problem now and not just kick it down the road. The AMA does not support any motion to recommit that would have a temporary fix.

I want to yield at this time to the gentleman from California (Mr. STARK).

Mr. STARK. I thank the gentleman for yielding only to suggest that being nice doesn't seem to get you much around here.

This motion makes a mockery of the debate. My friends on the other side simply propose the same old same old. They can't even tell us or the American people how this will affect doctors or military families or others. It is legislating in the dark.

The distinguished minority whip voted in committee enthusiastically for the bill that is before us, now seems to have forgotten and changed his mind. It is a continuation of the Republican history of mismanagement of Medicare and dishonest budget gimmicks, and I urge its opposition.

Mr. WAXMAN. Mr. Speaker, I yield to the gentleman from Florida (Mr. BOYD).

Mr. BOYD. Mr. Speaker, I appreciate the gentleman from California yielding.

As we have seen so many times in the past, ladies and gentlemen, the minority party has again offered a very insincere proposal that does not fix the issue at hand. This proposal is a gimmick that would eventually lead to deep cuts in Medicare.

In contrast, this underlying bill recognizes that the current baseline of physician spending is no longer useful in projecting obligations for providing physician services to Medicare beneficiaries.

The underlying bill fundamentally addresses this issue that Congress has acted on six times in the last 6 years for a temporary patch that has only made the problem worse. That is what they want to do again.

As my colleague, Ranking Member PAUL RYAN, mentioned earlier, this issue should be resolved in a bipartisan way, but that is not forthcoming here today. In the meantime, we must ensure that our seniors have access to their doctors.

In addition, this bill also addresses the pay-as-you-go rule. Under Republican rules, record surpluses were turned into record deficits as the pay-as-you-go rules expired. We cannot police ourselves with regard to fiscal discipline. That is why we have to have these rules in place. My Blue Dog colleagues and I have urged implementation of this policy for years.

I urge a ''no'' vote on the MTR and a ''yes'' vote on the underlying bill.

Mr. WAXMAN. Mr. Speaker, I urge a ''no'' vote on the motion to recommit and an ''aye'' vote on the underlying bill, and I yield back the balance of my time.

PARLIAMENTARY INQUIRIES

Mr. CANTOR. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. CANTOR. Mr. Speaker, is it true that the Democrats' bill will add $210 billion to the deficit?

The SPEAKER pro tempore. The Chair does not respond to commentary posed as a parliamentary inquiry.

Mr. CANTOR. Further parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. CANTOR. Mr. Speaker, my prior inquiry asked: Would the Democrats' bill add $210 billion to the deficit, and I would say even the Blue Dogs know that the Democrat bill adds $210 billion to the deficit.

The SPEAKER pro tempore. The gentleman from Virginia has not stated a parliamentary inquiry.

Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. CANTOR. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on the motion to recommit will be followed by 5-minute votes on passage of the bill, if ordered, and the motion to suspend the rules on H.R. 1834.

The vote was taken by electronic device, and there were—ayes 177, noes 252, not voting 5, as follows:

[Roll No. 908]

AYES—177

Aderholt	Garrett (NJ)	Neugebauer
Adler (NJ)	Gerlach	Nunes
Akin	Gingrey (GA)	Olson
Alexander	Gohmert	Paul
Altmire	Goodlatte	Paulsen
Austria	Granger	Pence
Bachus	Graves	Peterson
Barrett (SC)	Guthrie	Petri
Bartlett	Hall (TX)	Pitts
Barton (TX)	Harper	Poe (TX)
Biggert	Hastings (WA)	Posey
Bilbray	Heller	Price (GA)
Bilirakis	Hensarling	Putnam
Bishop (UT)	Herger	Radanovich
Blackburn	Hoekstra	Rehberg
Boehner	Hunter	Reichert
Bonner	Inglis	Roe (TN)
Bono Mack	Jenkins	Rogers (AL)
Boozman	Johnson (IL)	Rogers (KY)
Boustany	Johnson, Sam	Rogers (MI)
Bright	Jones	Rohrabacher
Brown-Waite, Ginny	Jordan (OH)	Rooney
Buchanan	King (IA)	Ros-Lehtinen
Burgess	King (NY)	Roskam
Burton (IN)	Kingston	Royce
Buyer	Kirk	Ryan (WI)
Calvert	Kosmas	Sanchez, Loretta
Camp	Lamborn	Scalise
Campbell	Lance	Schmidt
Cantor	Latham	Schock
Cao	LaTourette	Sensenbrenner
Capito	Latta	Sessions
Cassidy	Lee (NY)	Shadegg
Castle	Lewis (CA)	Shimkus
Chaffetz	Linder	Shuster
Childers	Lipinski	Simpson
Coble	LoBiondo	Smith (NE)
Coffman (CO)	Lucas	Smith (NJ)
Conaway	Luetkemeyer	Smith (TX)
Crenshaw	Lummis	Souder
Culberson	Lungren, Daniel E.	Stearns
Davis (KY)	Mack	Stupak
Deal (GA)	Manzullo	Sullivan
Dent	Marchant	Taylor
Diaz-Balart, L.	McCarthy (CA)	Terry
Diaz-Balart, M.	McClintock	Thompson (PA)
Dreier	McCotter	Thornberry
Duncan	McHenry	Tiahrt
Ehlers	McKeon	Tiberi
Emerson	McMahon	Turner
Fallin	McMorris Rodgers	Upton
Flake	Mica	Walden
Fleming	Miller (FL)	Wamp
Forbes	Miller (MI)	Westmoreland
Fortenberry	Miller, Gary	Whitfield
Foxx	Moran (KS)	Wilson (SC)
Franks (AZ)	Murphy, Tim	Wittman
Frelinghuysen	Myrick	Wolf
Gallegly		Young (AK)
		Young (FL)

NOES—252

Abercrombie	Brown, Corrine	Davis (AL)
Ackerman	Butterfield	Davis (CA)
Andrews	Capps	Davis (IL)
Arcuri	Capuano	Davis (TN)
Baca	Cardoza	DeFazio
Bachmann	Carnahan	DeGette
Baird	Carney	Delahunt
Baldwin	Carson (IN)	DeLauro
Barrow	Castor (FL)	Dicks
Bean	Chandler	Dingell
Becerra	Chu	Doggett
Berkley	Clarke	Donnelly (IN)
Berman	Clay	Doyle
Berry	Cleaver	Driehaus
Bishop (GA)	Clyburn	Edwards (MD)
Bishop (NY)	Cohen	Edwards (TX)
Blumenauer	Cole	Ellison
Blunt	Connolly (VA)	Ellsworth
Boccieri	Conyers	Engel
Boren	Cooper	Eshoo
Boswell	Costa	Etheridge
Boucher	Costello	Farr
Boyd	Courtney	Fattah
Brady (PA)	Crowley	Filner
Brady (TX)	Cuellar	Foster
Braley (IA)	Cummings	Frank (MA)
Broun (GA)	Dahlkemper	Fudge

Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Herseth Sandlin
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Issa
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kline (MN)
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Pingree (ME)
Platts
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Sutton
Tanner
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Towns
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOT VOTING—5

Brown (SC)
Carter
McCaul
Melancon
Miller, George

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1622

Mr. CLEAVER changed his vote from ''aye'' to ''no.''

Mr. LAMBORN changed his vote from ''no'' to ''aye.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. WAXMAN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 243, noes 183, not voting 8, as follows:

[Roll No. 909]

AYES—243

Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown, Corrine
Burgess
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Carson (IN)
Castor (FL)
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Costa
Costello
Courtney
Crowley
Cuellar
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Edwards (MD)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Foster
Frank (MA)
Fudge
Garamendi
Giffords
Gonzalez
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Higgins
Hill
Himes
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Johnson (GA)
Johnson, E. B.
Kagen
Kanjorski
Kaptur
Kildee
Kilpatrick (MI)
Kilroy
Kind
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kratovil
Kucinich
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis (GA)
Loebsack
Lofgren, Zoe
Lowey
Luján
Lynch
Maffei
Maloney
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Perlmutter
Perriello
Peters
Pingree (ME)
Polis (CO)
Pomeroy
Price (NC)
Quigley
Rahall
Rangel
Reyes
Richardson
Rodriguez
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Teague
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Tsongas
Van Hollen
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Woolsey
Wu
Yarmuth

NOES—183

Aderholt
Akin
Alexander
Austria
Bachmann
Bachus
Baird
Barrett (SC)
Bartlett
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boozman
Boren
Boustany
Broun (GA)
Brown-Waite, Ginny
Buchanan
Burton (IN)
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Cassidy
Castle
Chaffetz
Coble
Coffman (CO)
Cole
Conaway
Cooper
Crenshaw
Culberson
Davis (KY)
Deal (GA)
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dreier
Duncan
Edwards (TX)
Ehlers
Emerson
Fallin
Flake
Fleming
Forbes
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves
Guthrie
Hall (TX)
Harper
Hastings (WA)
Heller
Hensarling
Herger
Herseth Sandlin
Hoekstra
Hunter
Inglis
Issa
Jenkins
Johnson (IL)
Johnson, Sam
Jones
Jordan (OH)
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Kosmas
Lamborn
Lance
Latham
LaTourette
Latta
Lee (NY)
Lewis (CA)
Linder
Lipinski
LoBiondo
Lucas
Luetkemeyer
Lummis
Lungren, Daniel E.
Mack
Manzullo
Marchant
McCarthy (CA)
McClintock
McCotter
McHenry
McKeon
McMahon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy, Tim
Myrick
Neugebauer
Nunes
Olson
Paul
Paulsen
Pence
Peterson
Petri
Pitts
Platts
Poe (TX)
Posey
Price (GA)
Putnam
Radanovich
Rehberg
Reichert
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Souder
Stearns
Sullivan
Taylor
Terry
Thompson (PA)
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walden
Wamp
Westmoreland
Whitfield
Wilson (SC)
Wittman
Wolf
Young (AK)
Young (FL)

NOT VOTING—8

Brady (TX)
Brown (SC)
Carter
Kennedy
McCaul
Melancon
Miller, George
Towns

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1629

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. KENNEDY. Mr. Speaker, I regret that my vote on H.R. 3961, the Medicare Physician Payment Reform Act of 2009 was not recorded in the House of Representatives today.

Had my vote been recorded on rollcall No. 909, final passage of H.R. 3961, the Medicare Physician Payment Reform Act of 2009, I would have voted ''aye'' on the question.

Mr. BRADY of Texas. Mr. Speaker, on rollcall No. 909, I was unavoidably detained. Had I been present, I would have voted ''no.''

NATIVE AMERICAN BUSINESS DEVELOPMENT ENHANCEMENT ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the bill, H.R. 1834, as amended, on which the yeas and nays were ordered.

The Clerk read the title of the bill.