We are all very proud of you and thank you for your hard work.

With Love,

GRANDPA.

Mr. Speaker, Jim Rice will be missed, but not forgotten.

INTRODUCTION OF THE COMMODITY EXCHANGE ACT AMENDMENTS OF 1997

HON. THOMAS W. EWING

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. EWING. Mr. Speaker, today I am reintroducing legislation to reform the Commodity Exchange Act [CEAct] which governs the regulation of futures and options on U.S. commodity exchanges and other risk management financial instruments that are traded in over-the-counter markets.

This legislation is identical to H.R. 4276 introduced in the 104th Congress. Briefly, the legislation provides a conditional exemption for certain transactions involving professional markets, clarifies the effect of the designation of a board of trade as a contract market, simplifies the process for submission and disapproval of contract market rules, regulates audit trail requirements, establishes cost-benefit analysis requirements, repeals the Commodity Futures Trading Commission's deficiency order authority, and clarifies the impact of the section 2(a)(1)(A)(ii) of the CEAct commonly known as the Treasury amendment.

The purpose of the legislation is to assure the competitiveness of the U.S. futures industry, to preserve the vitality of price discovery and hedging functions of the futures markets and to recognize the impact of technology on our markets. The legislation I am introducing today is designed to serve as a discussion document as the House Agriculture Committee prepares to debate the many issues involved in reform of the CEAct.

In an effort to further discussion, the committee has requested comment from industry representatives directly and indirectly impacted by the CEAct including producer groups, self-regulating organizations, exchanges, the Commodity Futures Trading Commission, and the U.S. Department of Agriculture. I look forward to working with interested entities in the industry and with my colleagues on both sides of the aisle as we proceed with this necessary reform.

TRIBUTE TO THE MINNESOTA VETERINARY MEDICAL ASSOCIATION ON ITS 100TH ANNIVERSARY

HON. JIM RAMSTAD

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. RAMSTAD. Mr. Speaker, I rise today to pay tribute to the members of the Minnesota Veterinary Medical Association and its members' 100 years of faithful service to Minnesotans.

Over the years, the members of the association have provided exceptional animal health care, food safety, and public health services through the adherence to the highest professional standards of veterinary medicine.

The association was founded in 1897 by 13 veterinarians to further cultivate the science and art of comparative medicine and to promote livestock production as a branch of the agricultural industry. They also worked to protect high educational and ethical standards within their profession and to promote educational opportunities for the veterinarians of Minnesota.

Mr. Speaker, the veterinarians of Minnesota have been a crucial health care provider for the animal population in my State for the last 100 years—making consumers, pets, their owners, and the rural economy of our State a healthier place. I wholeheartedly applaud the 1,400 current members of the association for their dedication and service to the people of Minnesota.

TRIBUTE TO LIA B. BOWLER

HON. JAMES M. TALENT

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. TALENT. Mr. Speaker, I rise today to honor the outstanding accomplishments of 2d Lt. Lia B. Bowler. In December, Ms. Bowler successfully completed Marine Corps Officer Candidate School. In the fine tradition of the corps, she persevered through the rigors of the training and was accepted into the elite group of Americans that serve our country as officers in the Marine Corps.

Yet, Mr. Speaker, I rise today not only to congratulate Ms. Bowler on her commission, but also to recognize her outstanding work for the Second Congressional District of Missouri. We had the honor of her service first as an intern and later as our system administrator. In the almost 2 years she worked in the Washington office, she exhibited a dedication, diligence, and professionalism which were highly valued by everyone who worked with her. Although her loss to the Marine Corps will be felt by our office, it will be a gain for the Marines. Therefore, it is with great confidence that I can say her service as an officer will be in the highest traditions of the corps.

INTRODUCTION OF LEGISLATION TO CORRECT MEDICARE BENEFICIARY OVERCHARGES IN HOSPITAL OUTPATIENT DEPARTMENTS

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. STARK. Mr. Speaker, I am today introducing with Representative WILLIAM COYNE a bill to correct a glaring failure in the Medicare program—the massive over-charging of beneficiaries in hospital outpatient departments [HOPD's].

This bill will save Medicare disabled and senior beneficiaries about $35.7 billion between 1999 and 2003. It will stop the steady, upward climb in the percentage of HOPD costs that beneficiaries have to pay. Usually beneficiaries pay 20 percent of a set fee schedule for part B services. The way the HOPD law was drafted, however, has caused the beneficiary share of HOPD costs to climb to about 45 percent of outpatient department revenues. If the law is not corrected, seniors will pay an ever-increasing percentage.

Our bill will stop the rise in the beneficiaries' effective percentage payment and return it to the 20 percent that Medicare beneficiaries were promised. There are reports that the President's Medicare budget proposal will include a correction of the HOPD problem, but over a 10-year period. The President is to be congratulated for finally addressing this issue. We believe it should be done more quickly, and would like to work with interested parties to find the best way to pay for this program improvement at the same time we are making other savings to extend the life of the Medicare part A trust fund.

The HOPD problem is a serious one, with no easy solutions. In 1995, the Secretary of HHS presented a lengthy report to Congress that discussed a number of possible solutions—see attachment No. 1. We have adopted the basic ideas from that report and establish an HOPD prospective payment system and a correction of what is known as the formula-driven overpayment [FDO].

How did this problem arise? Hospital outpatient departments do all kinds of things like tests, x rays, and surgeries that the Secretary of HHS has determined can be safely done in an outpatient setting. HOPD services are paid under Part B. The key to the problem lies in the fact that Medicare pays HOPD's on a reasonable cost basis and not based on a prospective payment system [PPS] or fee system. Since costs are determined retroactively, the hospitals get paid retroactively by Medicare, but bill the patient at the time of service. At the time the patient gets the service and leaves the HOPD, we are unable to say for sure what the patient's 20 percent copayment is, since there is no set schedule of fees. As a result, the system was established in such a way that coinsurance is calculated based on charges at time of service. The charges, of course, may have little or no relation to costs and have crept up over time relative to what Medicare ends up actually paying for the cost of the service. So instead of paying 20 percent of a set and known fee, the seniors and disabled are paying 20 percent of charges. In 1996, this has become the equivalent of about 45 percent of the total payment to the hospital, Medicare plus coinsurance.

There is often a complication in the payment system I've just described for certain types of services provided in HOPD's, which results in what is called a formula-driven overpayment. If the surgery done in the HOPD is one that could have been done in an ambulatory surgery center and ASC's do about 2,700 different kinds of procedures, so there is a lot of overlap, then the amount of the Medicare payment is calculated differently. The payment calculation is also determined differently for radiology and diagnostic services performed in hospital OPD's compared to other services. For these services, the payment is either the lower of: One, reasonable cost as I've described in the previous paragraph, or two; a blended amount that is based partially on the reasonable cost in No. 1 and partially on either the ASC payment rate, for surgical services, or the physician fee schedule, for diagnostic and radiology services.