

Mr. SHERMAN. I yield to the gentleman from Texas.

Mr. TURNER. Mr. Speaker, I want to join with the gentleman from North Carolina (Mrs. CLAYTON).

I come from east Texas. The area that I represent is still operating off the old economy. The new economy had not made it there yet. And the old economy is not doing so well in rural America and inner city America.

That is why I feel so strongly, as my colleague does, about Congress making the right choices with regard to how we handle our Federal spending, our tax cuts.

As Democrats, we believe in tax cuts and we believe in tax cuts that are aimed at the people that really need them. I think it is important for us in trying to engage in this dialogue with the American people for them to understand that we want to see taxes go down just as much as anyone else in this body. But we want it to happen in a way that is good for the sustained, long-term growth of this country; and paying down the debt is a part of that, and we need to make that a priority.

I want to thank the gentleman from California (Mr. SHERMAN) for leading in this hour. It has been very informative to hear an individual with his background in accounting and finance talk about the details of the tax proposals that have been before this House in the last 10 days. I commend him for his leadership on these issues.

I know the gentleman from North Carolina (Mrs. CLAYTON) joins me as we all try to move forward together and try to accomplish things that will bring us a better future for all of our children and our grandchildren.

Mr. SHERMAN. Mr. Speaker, I have a few more examples and facts I want to quickly get into the RECORD. I promised I would wrap up just a few minutes after 4. We could, obviously, continue for another hour.

But let me first just make sure this RECORD reflects the analysis of citizens for tax justice. I mentioned it earlier that 45 percent of the benefits in the Republican package go to the top one percent of American families.

These families, on average, will save \$54,000. These families typically have incomes of over three-quarters of a million dollars a year already.

So the decision on who should benefit from this tax bill is as severely mistaken as the analysis that led to the unreasonable and fiscally irresponsible size of the tax bill.

□ 1600

Finally, for those who listened to the debates just before the tax bill was adopted, from time to time a Member of the majority would stand up and say, after a Democrat had spoken, do you realize the family in your State on average will save \$3,000 or \$3,500 under the tax bill?

It sounded like a big number. Let me make sure that that is corrected. Yes, indeed, the, quote, average person in

my State would save \$3,500. That is over a 10-year period. So that is \$350 a year. But that is the average person. Not the median but the mean.

Let me just explain the difference. If you have got Al Checchi, the gentleman, you may remember, who owns about half of Northwest Airlines, spent a lot of money in my State running for governor. If Al saves \$10 million on his taxes and then we have got 1,000 families in another part of my district saving \$10 on their taxes, well, that all averages up to a much higher number. The average simply looks at the huge amount of the tax break and divides it by the number of families. But the mean is when you look at the typical average family, what do they get. And typically under this tax bill, they get about 30 cents a day.

For God's sake, let us not risk America's current and tenuous prosperity, let us not risk this economic expansion on the joy that a few will get in giving tax breaks to a very few Americans, and certainly let us not risk this economic recovery and economic expansion on 30 cents a day of tax cuts for the average American family.

MEDICARE

The SPEAKER pro tempore (Mrs. BIGGERT). Under the Speaker's announced policy of January 6, 1999, the gentleman from Connecticut (Mrs. JOHNSON) is recognized for 60 minutes as the designee of the majority leader.

Mrs. JOHNSON of Connecticut. Madam Speaker, I rise today to address the increasingly acute, immediate problems in our Medicare program, one of the pillars of retirement security for America's seniors. It is significant that I rise at a time when Republicans, Democrats, the Congress and the President recognize that Medicare must include a new prescription drug benefit. While I strongly agree that we need to add prescription drugs to the Medicare system, we must provide coverage prudently and fairly and not by endangering funding for other Medicare services. Medicare simply cannot tolerate the scheduled deep cuts ahead, much less the billions of dollars in cuts proposed by the President in his budget and in the outline of his prescription drug proposal. I fervently believe that we must address the current problems immediately or hundreds of providers nationwide will close their doors, creating a crisis in access to care for our seniors of unprecedented proportions.

My purpose in this speech today is not to address long-term reform of Medicare nor the crying need to provide access to prescription drugs through Medicare, as important as those issues are to strengthening this crucial seniors' security program.

My purpose is more mundane and more urgent. It is critical to assuring seniors' access to quality care now and to assuring the survival of critical community health care institutions like our local hospitals, home health agencies and nursing homes.

In 1997, Congress adopted many reforms to Medicare because it was galloping toward bankruptcy. Already in 1997, it was paying out more for services than it was collecting in payroll taxes and premiums. Medicare spending was exploding, especially in the areas of home health and skilled nursing facility costs. And as it reached the unsustainable level of 11 percent growth per year, the Balanced Budget Act reforms were adopted to cut this growth rate in half, from 11 percent to 5.5 percent, a modest and responsible goal.

Why, then, are home health agencies, nursing homes and hospitals begging us to hear their problems and pleading for relief? Alas, it is simple. The projected savings from the Balanced Budget Act were \$106 billion over 5 years. The real savings that will be achieved are about \$100 billion above that. While the goal was to slow the rate of growth to 5.5 percent, growth has dropped to 1.5 percent, though the number of seniors and frail elderly continues to grow.

I believe we face a crisis and must act now. While the data from the real world has not reached the shores of Washington, in the real world in my estimation the crisis is immediate and beginning to endanger the quality of care available under Medicare. Seniors' access is at stake and the very institutions we depend on for care are at risk.

There are five causes for the very serious problems we face in Medicare:

First, though a relatively minor factor, important mistakes were made in writing the Balanced Budget Act reforms.

Second, bureaucratic problems have developed and are delaying payments to providers for many, many months.

Third, the reform bill included expanded funding and authority to eliminate fraud and abuse. As a result, the Inspector General has not only identified and eliminated a lot of fraud and abuse but has changed many rules, delaying payments unmercifully and unfairly in my mind. Further, the fear of the Inspector General is causing some providers to cancel negotiated discounts and pushing costs up as reimbursements are going down, all because the Inspector General is ignoring old rules and refusing to clarify new ones.

Fourth, the fact that rates are based on data that is 4 years old is exacerbating our problems dramatically.

And, fifth and possibly the most significant cause of the looming crisis is the unintended and unanticipated consequences of the interaction of the many changes in payment levels and payment systems made by both public and private payers over a short period of time.

In fairness, we have placed enormous burdens on the good people of the Health Care Financing Administration which administers Medicare and their claims processors and on the providers with the level of changes that we have enacted. It would be sheer hubris to believe that so many changes could be

implemented without unintended consequences, especially as they are interacting with private sector changes of a pace and a breadth unprecedented. Not surprisingly, there are slowdowns in the payments, real mistakes to be corrected and unanticipated problems to be solved. There is no shame in the problems. The shame would be if we did not address them this Congress.

We must simply have the political courage to examine the concerns of the providers and deal with those that are legitimate, and we must have the courage to fund the changes from the surplus we have set aside for retirement security since many of what we call surplus dollars are dollars we appropriated to spend on care for Medicare patients and that are needed by those very patients.

Some people are discouraging action and criticizing providers for whining. Not so. Go visit hospitals, nursing homes, home health agencies and physicians. Changes made and the additional cuts of \$11 billion proposed by the President in his budget will, I think, put providers in severe constraints, put many small providers out of business, and will go directly to affect access and quality of care for our seniors. We cannot expect facilities to simply absorb millions of dollars of loss without compromising their role in our communities. We cannot expect small providers that are not getting paid for many months to be able to meet payroll, provide medications and meet the standard of care we expect.

Over the August District Work Period, I encourage my colleagues to meet with providers in their district and listen to what they are going through, see what precisely they are facing and the impact the current law cuts in the HCFA administration, the administrators of Medicare, their actions are having on service availability and quality. Then make your judgment. I think you will come to the same conclusion that I have. Through many visits to hands-on caregivers, I am convinced that providers cannot survive if we do not act and the administration does not provide relief from policies that are harsh and unfair and begin spending the full appropriation provided for Medicare services.

Congress must listen up and act. The administration, HCFA, the agency that governs the Medicare program, must also listen up and act, for it will take all of us working hard and now to prevent a catastrophic loss of providers, research capability and sophisticated treatment options.

We do not need to fundamentally undo the reforms adopted in 1997. In fact, we cannot undo those reforms because we must succeed in slowing the rate of growth in Medicare. But we must act now to respond to the doubly deep cuts that resulted unintentionally from the law to preserve access to needed health care services and ensure community providers will survive.

I will now look at each sector, nursing homes, hospitals and home health

agencies, to suggest administrative fixes in the way the balanced budget is being implemented and legislative changes to the policies enacted, in other words, actions that the executive branch can take immediately and laws, legal changes, that the Congress must adopt.

In the area of payments to skilled nursing facilities, we expected to save \$9.5 billion through the Balanced Budget Act, but the savings are now estimated at \$16.6 billion, more than half again as much.

There are two administrative policies that together have delayed payments to nursing homes so severely that literally payrolls will not be met if relief does not come soon, spelling closure for good facilities providing compassionate care.

First, HCFA needs to repeal sequential billing for nursing homes. The balanced budget reforms required nursing homes to coordinate and pay for all ancillary services given to Medicare patients in nursing homes, but the law does not require sequential billing. If one ancillary service provider is late in submitting their bill, the nursing home is late in submitting its bill to Medicare. This creates a domino effect of payment delays when we require all of May's bills to be settled before June's bills can be looked at. HCFA, the Medicare administrator, has announced that they are ending sequential billing for home health agencies and they should repeal this destructive and unfair policy for nursing homes. Payments for room, board and regular services need to flow predictably as they have in the past while the problems with the ancillary services billing system are ironed out. This will prevent the serious cash flow problems that threaten small providers, particularly small providers in our rural areas and small cities.

Secondly, the administration must speed up Medicare payment denials. In my region, nursing homes are having difficulty getting payment denials from Medicare. The real world problem for providers is that they cannot bill other payers, such as Medicare or the private sector, until they get a payment denial from Medicare. Yet they are providing care month after month, often borrowing money, accruing interest charges and endangering their solvency and licensure. We also need to ensure that these denials are written in clear language. Even when providers do get letters of denial, the language is so convoluted and legalistic that it is difficult to determine whether a payment has been denied or not.

In addition to these two administrative actions, which I urge the Health Care Financing Administration to take promptly to relieve the terrible strain on nursing homes that threatens the institutional survival of some, there are legislative corrections to the Balanced Budget Act that we must make if quality care is to be maintained.

□ 1615

First, we must fairly address the issue of medically complex patients. There is clear evidence that the payments under the nursing home prospective payment system are not sufficient to pay for the medical needs of the acutely ill patient.

The General Accounting Office testified before the Senate Finance Committee that, and I quote, certain other modifications to the prospective payment system must be, may be appropriate because there is evidence that payments are not being appropriately targeted to patients who require costly care. The potential access problems that may result from underpaying for high-cost cases will likely result in beneficiaries staying in acute care hospitals longer rather than foregoing care, end quote.

Indeed, I have already heard about this problem from the hospitals in my district, yet we cannot expect hospitals to continue to treat patients without compensation simply because there is not a nursing home that can afford to care for them, nor can we expect nursing homes to accept patients for whose care they will not be paid sufficiently.

The Health Care Financing Administration has also testified about its concern that the prospective payment system, and I quote, does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients, unquote. HCFA announced that they were conducting research that will serve as the basis for refinements to the resource utilization groups that we expect to implement next year.

It is good that HCFA has recognized that we do not have the data to account for the cost of medications for acutely ill patients, but gathering the data for next year is not an acceptable solution. We cannot ignore patients and care providers who are facing serious problems now. We must take immediate action to direct increased payments to the sicker patients or to allow nursing homes to bill directly for drugs until we have better data to refine the payment system.

Secondly, we must exclude ambulance, the cost of ambulance rides and prosthetic devices from the current payment system. When Congress passed the prospective payment system, we did not expect to require that nursing homes cover the cost of ambulance transport.

Fortunately, the Health Care Financing Administration has exempted several types of ambulance transportation from the payments, but they are still requiring that nursing homes pay for the cost of ambulance transport when it is necessary as part of a patient's treatment plan. This requirement is terribly burdensome for rural nursing homes that face significant charges for long ambulance trips. A rural nursing home in my district gets \$200 a day in Medicare payments. An ambulance ride to the nearest hospital costs \$800. How could such a home accept a dialysis patient who needs regular transportation

to a dialysis facility for treatment? We do not require the nursing home to pay for the cost of dialysis treatment, but we are requiring to pay for the transportation associated with that treatment.

The same is true for radiation treatments. We should exclude these types of transport charges from the prospective payment system and fold them into the negotiated rulemaking process that is currently under way to set an ambulance fee schedule.

It is also difficult for a nursing home to serve an amputee because of the high cost of prosthetic devices. The cost of these devices can often run from 2 to \$7,000. It is impossible for a facility to accommodate this cost in their 2 to \$400 a day reimbursement and still provide all the services necessary for a patient to recover from an amputation. The patient cannot get the device while they are in the hospital because their wound must recover, and they cannot wait until they have been discharged from the nursing home because they must begin to use it for therapy. So the nursing home must find a way to pay for it, and that is impossible without losing thousands of dollars on a case. That is unfair to both patient and nursing home.

In sum, if the Health Care Financing Administration moves swiftly to address administrative problems that it has the power to address and Congress acts on legislative issues, we can both meet the savings goal of the Balanced Budget Act for nursing homes and not lose the small homes that are truly at risk of closure though they provide wonderful care for our seniors.

And now to turn to hospital payment problems which are too numerous to detail here. Instead, I will mention only some of the most troublesome.

First, the balanced budget amendment projected savings of 48.9 billion from hospital reimbursements.

Currently the Congressional Budget Office projects savings of 52.6 billion. So the savings are being made in spite of major payment cuts in the law that have not yet gone into effect and now, I believe, are inappropriate. In fact, without relief, current law will dramatically escalate cuts in hospital reimbursements and severely damage our community hospitals as well as the medical centers on which we rely for sophisticated expertise, research into new treatments, training of new physicians and a great deal of uncompensated care for uninsured and low-income patients.

First, we must repeal the transfer policy. Hospitals are currently paid based on the average cost for caring for a patient with a specific disease. Naturally the facility will have some patients whose treatment requires them to stay longer than the average and some that will be able to be discharged earlier than the average. The difference in the cost to the hospital of the longer- and shorter-stay patients works well over all. The incentive is to

reduce the length of stay by getting patients to the most appropriate care setting, and this payment structure has indeed reduced the length of hospital stays dramatically.

Starting in the Balanced Budget Amendment, however, through enactment of the transfer policy, we began to send hospitals a completely different message about how they treat patients by reducing payment for patients referred to nursing homes, long-term care hospitals or home health agencies. We know that the bulk of the cost of hospital care is eaten up in the first few days of admission in which a procedure is done and tests are performed. Yet the transfer policy revokes the full prospective payment for the hospital and instead pays them at a lower per diem rate if a patient is transferred to another facility to recover or even to home care.

This policy must be repealed because it works against the positive incentives of the prospective payment system which has successfully over time reduced the length of hospital stays by providing less costly alternatives for recovery. Ironically, if a patient tells the hospital discharge planner that they have a relative who can care for them at home but that care-giver becomes overwhelmed or their circumstances change and they cannot provide home care, the transfer policy penalizes the hospital by reducing its payments simply because the patient now legitimately needs home care services. That is unfair to the patient and to the hospital.

In addition to repealing the transfer policy, which we must do legislatively, the Health Care Financing Administration must not go forward with a 5.7 percent cut in reimbursements for outpatient services, which was clearly not intended by Congress. The Health Care Financing Administration's interpretation of the law would effectively implement a 5.7 percent across-the-board cut in payments to outpatient departments. That would be a heavy cut.

It is clearly inconsistent with Congress' intent and threatens to undercut support for what had been a delicately balanced policy compromise. The House and Senate language in the 1997 bills was identical regarding our outpatient policy clearly precluding this payment reduction, and the conference report reiterated that no change was intended.

Further, the 1997 bill included a 7.2 billion outpatient payment reduction, but no additional payment reductions were discussed nor contemplated by Congress nor were analyzed or scored by the Congressional Budget Office. Congress' intent throughout a very long process was very clear that total payment to hospitals for outpatient services was to be budget neutral to a clearly identified new baseline in the law that did save money.

No additional hospital outpatient payment reduction of the type outlined in the notice of proposed rulemaking

was contemplated. The department should carry out Congress' clear intent and withdraw the proposed rule. It would be inappropriate and destructive to impose 850 million per year of additional payment cuts on hospital outpatient departments. Seventy-seven Senators have signed a letter to the Health Care Financing Agency saying just this, and I am seeking your signatures on a similar letter to get this problem addressed now.

Thirdly, the Health Care Financing Administration must recognize the true cost of cancer drugs in the outpatient prospective payment system. The Medicare Payment Advisory Commission has reported to Congress a concern that the method of developing payments under the outpatient PPS system is likely to overpay for some services, and I quote, "and underpay for others," unquote. HCFA has developed payments on aggregate failing to recognize the high costs associated with individual patients. This has a particularly dramatic impact on cancer treatments.

HCFA's current proposed rule fails to recognize the complexities of chemotherapy, individual drug costs, and most importantly, differing medical needs of cancer patients. As a result, the new system will create financial incentives that may lower the quality of care available to cancer patients and restrict their access to care. HCFA needs to follow MEDPAC'S recommendations and adjust the outpatient payment system to reflect the complexity of care within hospital outpatient departments.

Fourthly, HCFA must recognize the higher cost of treating patients in cancer institutes. There are 10 cancer centers throughout the country that are distinguished from other acute-care hospitals because they are devoted exclusively to the treatment of cancer patients. These facilities provide the most up-to-date cancer treatments available, are on the cutting edge of research, develop many of their new treatments for patients, and are now treating 50 percent of their cancer patients in the outpatient setting, reducing the cost of providing care.

We have recognized them as distinct hospitals by making them exempt from the acute-care perspective payment system, and in the Balanced Budget Act we directed HCFA to consider establishing a separate payment methodology for cancer centers. HCFA has failed to do this in their proposed regulation, and their initial analysis of the new payment system is that payments to cancer centers will fall by one-third compared to a 5 percent decline across all hospitals.

MEDPAC has recognized this problem and recommended that HCFA modify its payment rationale to better reflect the needs of cancer center outpatient departments. Such administrative remedies are extremely important to preserving access to high-quality care in outpatient and cancer centers;

but as important as they are to stemming overly severe cuts and hospital reimbursements legislative action is also required.

First, we must pass a stop-loss bill to prevent sudden and deep cuts in outpatient payments. According to MEDPAC, Medicare paid hospitals only 90 cents for each dollar of outpatient care provided prior to the 1997 Balanced Budget Act. The balanced budget has further reduced this to 82 cents for every dollar. Once the proposed outpatient PPS system is in place, hospitals will lose an additional 5.7 percent on average if the administration does not act in accordance with Congress' intention.

□ 1630

And some hospitals will be impacted even further.

More than half the Nation's major teaching hospitals would lose more than 10 percent, and nearly half of our rural hospitals would lose more than 10 percent. Catastrophic losses would be experienced in some individual hospitals.

For example, large hospitals in Iowa and New Hampshire, will immediately lose 14 to 15 percent of Medicare outpatient revenue. Other large, urban hospitals in Missouri, Massachusetts, Wisconsin, Florida, and California will lose 20 to 40 percent. Some small rural hospitals in Arkansas, Kansas, Mississippi, Washington, and Texas will lose more than 50 percent of their Medicare revenue.

We must enact legislation to limit the amount of losses that any hospital sustains. As more treatments are moving into the outpatient setting, we simply cannot expect hospitals to absorb losses of 15 percent and more. Legislation to limit losses will ensure that hospitals will still be able to treat patients, and Medicare will secure the savings it needs to remain solvent in the short term.

Secondly, we must legislatively prevent any further cuts in the disproportionate share of hospital payments. Many hospitals' emergency departments are the only option for people without health insurance, because they cannot refuse to see patients. With the increasing number of uninsured Americans, hospitals are bearing an increasing burden. Congress must reassess our cuts in disproportionate share of payments in light of the increasing number of uninsured, by freezing payments at their present levels.

Thirdly, we must increase the hospital update to reflect the costs of preparing for Y2K. MEDPAC has recommended that hospitals receive one-half to a 1 percent increase in their operating payments to account for the need to update information systems and medical devices to become Y2K compliant, year 2000 compliant. Perhaps more than any other industry, hospitals have had to spend significant amounts of money to update their systems because of the wide variety of devices and systems that they deal with.

I have talked with hospitals in my district that have had to replace entire systems and devices ahead of schedule to ensure that they will continue to operate after the clock strikes midnight at the close of this year. The replacements range from simple devices such as IV pumps to costly systems such as a monitoring system in the intensive care unit. It is important to note that the ICU monitoring system was only 8 years old and was not due to be replaced, but the Y2K computer glitch possibility made replacement necessary.

The Y2K problem is not something that hospitals could have planned in their operating and capital budgets a few years ago, but it is something they cannot afford to ignore.

The American Hospital Association survey of their membership shows that member hospitals will spend \$8.2 billion to become Y2K compliant. We should follow MEDPAC's recommendation to increase reimbursements to hospitals to reflect these additional costs.

Finally, immediate attention must be paid to the needs of our great teaching hospitals. These institutions have been particularly hard hit because they are affected by essentially all of the Balanced Budget Act changes, while most institutions are only affected by a few provisions. They deal with a large number of uninsured, have more acutely ill patients, because they serve as regional referral centers. They must train the specialists of the future and maintain cutting-edge technology. And they must use National Institutes of Health grants which require a 25 percent match from the institution to do the clinical research that we so deeply depend upon.

Madam Speaker, we must look at the way that all the payment changes adopted are affecting these hospitals and provide relief in this Congress.

Lastly, let us turn to home health agencies. In this sector, we projected that the Balanced Budget Act would save \$16 billion. We have now realized savings of \$48.8 billion, more than any other area. The Balanced Budget Act imposed significant changes on the home health industry, and we achieved the greatest savings in this area. I believe the high savings reflects the useful work of the Fraud and Abuse Unit, but through talking to my providers, I know a lot of nonpayment lurks behind that \$48.8 billion figure, and good agencies are on the brink of closure from both administrative actions by the government and the balanced Budget Act's effects.

First, having saved more than double the intended goal in home health services, we need to eliminate the threat of the 15 percent further additional reduction that will take place on October 1 in the year 2000.

While we put the 15 percent reduction in the system to ensure that there would be sufficient savings, we should remove the 15 percent, because the nec-

essary savings have been achieved, completely eliminating the 15 percent reduction. If we are to assure our sickest seniors that home health services will continue to be available, will be expensive, about \$7 billion over 5 years. But we should be able to accomplish this out of the savings that we have already generated, which are now making the surplus larger than expected.

We must also increase slightly the per-patient reimbursement limit, and the administration must stop the waste of revenues, the scandalous squandering of our resources that is taking place as a result of the high review rate in these agencies. It is a technical problem. It is administrative, but it is taking nurses away from care. It is raising administrative costs at an unprecedented rate, and HCFA must address this terrible problem of the high rate of post-payment reviews.

Lastly, we must raise the \$1,500 cap on rehabilitative therapy services for both home health care providers and nursing homes. The Balanced Budget Amendment implemented two caps on outpatient rehabilitative therapy services, a \$1,500 cap for occupational and physical therapy, and a \$1,500 cap for speech therapy. This is an arbitrary dollar limit that does not take into account the severity of a patient's illness. While this cap may be sufficient to provide services to many seniors, there are those who have multiple conditions or who have more than one illness in a career that quickly exceeds the \$15,000 allowed and must pay themselves or go to hospital outpatient departments.

The Health Care Financing Administration has identified this problem in testimony before the Senate Finance Committee, and I quote: "We continue to be concerned about these limits, and are troubled by anecdotal reports about the adverse impact of these limits. Limits on these services of \$1,500 may not be sufficient to cover necessary care for all beneficiaries."

HCFA has directed the Inspector General to study the cap to assess whether any adjustments to the cap should be made. MEDPAC has also expressed concern in this area. We need to get relief to the patients most in need, and not let them slip through the cracks.

This has been a long and sometimes technical Special Order; however, its message is simple. There are real, serious problems in today's Medicare program that are affecting care for seniors and threatening the future of some of our most beloved community hospitals, nursing homes, doctors' practices, and visiting nurses associations. We need to address these problems now, not next year, through targeted, immediate relief and through strong action.

Congress must act now. The administration must act now. At stake, I believe, is quality care for our seniors and indirectly for all of us who rely on our community hospital and community providers.

Mr. Speaker, I ask my colleagues to please join me in this crusade for action.

HCFA INTERPRETATION OF THE BALANCED BUDGET ACT AND ITS EFFECTS ON THE HEALTH CARE INDUSTRY

The SPEAKER pro tempore (Mrs. BIGGERT). Under a previous order of the House, the gentleman from Kentucky (Mr. FLETCHER) is recognized for 5 minutes.

Mr. FLETCHER. Madam Speaker, I appreciate the opportunity to speak after the gentlewoman from Connecticut (Mrs. JOHNSON), and I certainly concur with the things that she said.

I am getting ready to catch my flight back to Kentucky, actually, just in probably about an hour.

Madam Speaker, I just got a call from one of the nursing home companies back in Kentucky, and I have visited multiple of these nursing home units in Kentucky, as well as our rural hospitals and our teaching hospital at the University of Kentucky.

I think as we look at what interpretation HCFA has taken of the Balanced Budget Act of 1997, I think we have some critical problems that are facing our Nation, especially in the care of our elderly. We see that our rural hospitals are having trouble; several of them are looking at the possibility of closing their doors. We have nursing homes that are going bankrupt; even nursing homes that are run by faith-based organizations, church groups where they really have contributions in addition to what they receive from reimbursements from Medicare and Medicaid.

Yet we found that, with the very draconian interpretation of the Balanced Budget Act of 1997, we have such a reduction that even these operations that have operated very efficiently, not trying to defraud in any way, have been unable to really provide the services or to continue to provide the services that are needed for our senior citizens.

So I think it is incumbent upon us in Congress and to call upon HCFA and the President to make sure that they relook at the Balanced Budget Act of 1997 and HCFA's interpretation of that. I would also like to work with the Congress and make sure that we address this very critical problem, that we address the needs of our senior citizens.

As I talked to this one business owner who was very distraught, they have worked very hard at a family business to provide the kind of care that is needed for our senior citizens; and yet, when I see what a misinterpretation of the balanced budget has done in their capability of providing a business, they provide over 1,900 jobs in a business that has grown over several years to provide excellent health care in the long-term care business.

And I see that what the interpretation has done is caused the possibility

of driving that company into bankruptcy, affecting the care of a number of people, especially in my district, in the 6th district of Kentucky, and it has certainly affected their ability to provide the jobs and to provide the care that is needed.

Madam Speaker, I just wanted to take this opportunity to share my concerns that I certainly share with the gentlewoman from Connecticut that have been stated here previously.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. GOODE (at the request of Mr. GEPHARDT) for today and August 2 on account of a death in the family.

Mr. LUTHER (at the request of Mr. GEPHARDT) for today on account of a family commitment.

Mr. ORTIZ (at the request of Mr. GEPHARDT) for today on account of personal reasons.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. FILNER) to revise and extend their remarks and include extraneous material:)

Mr. PALLONE, for 5 minutes, today.

Mr. TANNER, for 5 minutes, today.

Mr. FILNER, for 5 minutes, today.

Ms. HOOLEY of Oregon, for 5 minutes, today.

Mrs. CLAYTON, for 5 minutes, today.

Mr. TURNER, for 5 minutes, today.

(The following Members (at the request of Mr. FOSSELLA) to revise and extend their remarks and include extraneous material:)

Mr. KASICH, for 5 minutes, today.

Mr. FOSSELLA, for 5 minutes, today.

ADJOURNMENT

Mr. FLETCHER. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 4 o'clock and 43 minutes p.m.), under its previous order, the House adjourned until Monday, August 2, 1999, at 12:30 p.m. for morning hour debates.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

3275. A letter from the Administrator, Agricultural Marketing Service, Department of Agriculture, transmitting the Department's final rule—Tart Cherries Grown in the States of Michigan, et al.; Additional Option for Handler Diversion and Receipt of Diversion Credits [Docket No. FV99-930-1 FIR] received June 24, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

3276. A letter from the Assistant Secretary, Pension and Welfare Benefits Administration, Department of Labor, transmitting the Department's final rule—Interpretive Bulletin 99-1; Payroll Deduction Programs for Individual Retirement Accounts (RIN: 1210-AA70) received June 24, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

3277. A letter from the Acting Director, Professional Responsibility Advisory Office, Department of Justice, transmitting the Department's final rule—Ethical Standards for Attorneys for the Government [AG Order No. 2216-99] received June 24, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

3278. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; Boeing Model 777 Series Airplanes [Docket No. 99-NM-113-AD; Amendment 39-11230; AD 99-15-10] (RIN: 2120-AA64) received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3279. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; deHavilland Inc. Models DHC-2 Mk. I, DHC-2 Mk. II, and DHC-2 Mk. III Airplanes [Docket No. 99-CE-05-AD; Amendment 39-11226; AD 99-15-07] (RIN: 2120-AA64) received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3280. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; MD Helicopters, Inc (MDHI) Model 369D and E Helicopters [Docket No. 99-SW-40-AD; Amendment 39-11228; AD 99-13-09] (RIN: 2120-AA64) received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3281. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Amendment to Class E Airspace; Ottawa, KS [Airspace Docket No. 99-ACE-21] received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3282. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Revision of Class D and Class E Airspace; Cannon AFB, Clovis, NM [Airspace Docket No. 99-ASW-02] received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3283. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 29642; Amdt. No. 1940] received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3284. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the Department's final rule—Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 29641; Amdt. No. 1939] received July 22, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

3285. A letter from the Program Analyst, Office of the Chief Counsel, FAA, Department of Transportation, transmitting the