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House of Representatives

WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 2614, CERTIFIED DEVELOPMENT COMPANY PROGRAM IMPROVEMENTS ACT OF 2000

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 652 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 652

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 2614) to amend the Small Business Investment Act to make improvements to the certified development company program, and for other purposes. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read.

The SPEAKER pro tempore (Mr. QUINN). The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

☐ 1130

Mr. LINDER. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MOAKLEY), pending which I yield myself such time as I might consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, H. Res. 652 is a typical rule providing for consideration of H.R. 2614, the conference report for the Certified Development Company Program Improvements Act of 2000.

The rule waives all points of order against the conference report and its consideration and provides the conference report shall be considered as read.

House rules provide 1 hour of general debate divided equally between the chairman and ranking minority member of the Committee on Small Business and one motion to recommit, with or without instructions, as is the right of the minority Members of the House.

I want to discuss briefly the conference report this rule makes in order. It includes important small business tax relief, community renewal and retirement security provisions, as well as

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WILLIAM M. THOMAS, *Chairman.*

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.
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long-term care and health care initiatives that benefit all Americans. In addition, this bipartisan measure includes H.R. 5538, legislation introduced by the gentleman from Ohio (Mr. TRAFICANT) to raise the minimum raise. This bipartisan language is patterned after the Traficant-Martinez amendment passed by the House earlier this year.

First, I am pleased that H.R. 2614 contains important tax relief provisions to help ease the burden on small businesses. It will also allow small businesses to expense additional qualifying properties costs, speed up the phase-in for deduction of meal expenses, and extend income-averaging benefits for farmers to include commercial fishermen. The conference report will also extend the Work Opportunity Tax Credit to assist businesses in hiring disadvantaged workers and repeal the installment method accounting requirement, an issue on which many of us have heard from our constituents.

H.R. 2614 also contains much needed provisions to increase retirement security for working people. It raises IRA limits to $5,000 and increases the contribution limits for 401(k)-type plans to $15,000. This bill also increases the portability of retirement plan assets and simplifies the pension system to encourage small businesses to offer pension plans.

This conference report also creates 40 Renewal Communities with targeted pro-growth tax benefits, regulatory relief, savings accounts, brownfields cleanup, and homeownership opportunities. It also includes a zero capital gains tax rate for business assets in these communities. These and other provisions will help ensure that all communities have an opportunity to share in our current prosperity.

I am pleased that conferees also included long-term care health care incentives to help make care more affordable and accessible. A substantial deduction for expenses related to long-term care and deductibility for the purchase of long-term care insurance policies will help ease the burden on seniors and their families.

H.R. 2614 also provides immediate 100 percent deductibility for health insurance for the self-employed and health care deductibility for people who purchase health care outside of their employer.

Finally, I am pleased that the conferees included the foreign sales corporation tax revision in this conference report. This provision will maintain current tax treatment for foreign sales corporation beneficiaries in a manner that the U.S. believes to be WTO compliant. I commend the conferees for the inclusion of this revision so important to our U.S. trade and our ability to compete in world markets.

This rule was favorably reported by the Committee on Rules. I urge my colleagues to support the rule today on the floor so that we may proceed with the general debate and consideration of this important conference report.

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

Mr. MOAKLEY. Mr. Speaker, I thank the gentleman from Georgia (Mr. LINDER), my friend, for yielding me the customary time, and I yield myself such time as I may consume.

Mr. Speaker, this rule really makes a mockery of the legislative process. I strongly urge my colleagues to oppose it, not only for the substance of the bill, but also for the process by which it is being brought to the floor.

Just to give my colleagues a little bit of the background, just before midnight last night, the Committee on Rules was informed that we would not meet until 8 o'clock this morning and that the House would stay in recess until we completed the consideration of these rules.

Once we met at 8 o'clock and filed the rules, the House adjourned immediately, and it immediately reconvened. This convoluted process has been in order to stretch one calendar day, the 26th of October, into two legislative days. The reason for that, Mr. Speaker, is because my Republican colleagues are then able to bring up a number of rules to the floor the very same day that they were reported out of the Committee on Rules. This way Members, particularly Democratic Members, have virtually no idea what is in these bills, especially, Mr. Speaker, since we were excluded from all the negotiations.

Mr. Speaker, this bill contains major unrelated provisions that look like everything but the kitchen sink. The tragic part, Mr. Speaker, it still does not do enough for high school construction or high school modernization.

Democrats want $25 billion in interest-free school construction financing over the next 10 years with prevailing wage protections. But, instead, this bill contains a school arbitrage provision which will only help schools that can delay school construction for 2 years.

Mr. Speaker, this is essentially a tax incentive to keep children in trailers and in dilapidated school buildings rather than building new schools. It contains only half of the Johnson-Rangel interest-free construction funding, and it leaves out the prevailing wage protections.

The first provision in the bill is a small business bill that is not particularly objectionable. The second is an excellent idea to raise the Federal minimum wage from $5.15 an hour to $6.15 an hour over 2 years.

Mr. Speaker, of the 10 million people who work for minimum wages in this country, most of them are women and minorities. They take care of our young children. They take care of our elderly parents. They cook our meals. They pump our gas. They clean our offices. They really deserve a raise.

But since this long overdue raise is being included in an otherwise bad bill, it very well might not get signed into law, and that might be just the way that my Republican colleagues want it.

The third provision is a package of tax cuts designed primarily to benefit the very rich, which will endanger our Social Security and Medicare by spending the budget surplus.

In order to enact the third provision of the bill, it also includes a fourth provision which would exempt, listen closely, this would exempt this enormous tax cut for the rich from the pay-go sequester that would automatically force cuts in Medicare, student loans and farm programs.

Essentially, Mr. Speaker, my Republican colleagues are turning off the effects of the current law to pass their tax cuts for the rich, even though these tax cuts will have a disastrous effect on the economy. As far as the pay-go scorecard goes, thanks to this bill, these tax cuts are free and so is every other entitlement increase and tax cut that we do in this Congress.

Mr. Speaker, the fifth provision is known as the balanced budget amendment fix. When my Republican colleagues passed the so-called balanced budget, they caused very dangerous cuts in Medicare. Hospitals, many of them in my district, found themselves faced with bankruptcy. Everyone, including my Republican colleagues, knew they had made a mistake and they needed to fix it.

So in response, this bill will replace some of the money that they so carelessly cut, but it is tilted dramatically in favor of HMOs and does not do anywhere near enough for the hospitals. Only about 15 percent of the Medicare enrollees are in HMOs, but the HMOs get 40 percent of the money in this bill. That, too, Mr. Speaker, may be a deal breaker.

Finally, Mr. Speaker, the sixth provision overturns Oregon's assisted suicide law.

In short, Mr. Speaker, this is a very important bill with very far-reaching consequences that has not even had the benefit of proper legislative consideration. Like so many other bills this session, it will help rich people instead of helping the working American families.

I urge my colleagues to oppose the previous question so that we can offer a Democrat alternative.

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

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

Mr. Speaker, I am just rising out of confusion as to whether the gentleman from Massachusetts (Mr. MOAKLEY) states that raising IRA limits to $5,000 is a tax cut for the rich. Does increasing contribution limits for 401(k) plans for regular workers, is that a tax cut for the rich? How about increasing the portability of retirement plans so people can move from one job to another? Is that just for the rich?

If we simplify the pension system to encourage small businesses to offer their employees pension plans, is that

another tax cut for the rich? We have got some small business tax relief in here to allow them to expense certain kinds of costs. Is this tax cuts for the rich? Or has the gentleman from Massachusetts (Mr. MOAKLEY) just pulled out on old speech and rerun it one more time?

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

Mr. MOAKLEY. Mr. Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, this is a pretty sad day in the House of Representatives. Yes, as the gentleman from Georgia (Mr. LINDER) just stood up a moment ago and mentioned, there are a couple of provisions in this bill that actually before today have seen the light of day, have gone through the legislative process, have been voted on by this House, such as the pension reform provisions, which I supported. But one cannot mix those up with a number of other things that have never ever gone through committee, never been voted on, never been published.

Sometime between midnight and 7 a.m., behind closed doors, a few Republican leaders cobbled together a year-end tax bill designed to get a veto from the President so they can say, ''Look what we would have done if only Bush, Jr., was in the White House. Look what we will do next year. We will give the HMOs all the money, lock, stock and barrel. We will sell out the patients. No Patients' Bill of Rights. No quality controls. No cost controls. But billions more for the HMO plans, a blank check.'' That is in this bill.

There are other outrageous provisions, but I have got to focus on one that is extraordinarily outrageous. Twice, two times, two times the people of Oregon have gone to the ballot box, once by initiative and once by referral from a Republican legislature, to uphold the principle of assisted suicide, death with compassion for people with terminal illness.

Now, if the right wingers around here are offended by that, every other day of the week, they are for States' rights. But guess what? When a State does something they do not like, they are not for States' rights anymore.

They passed the bill in the House to overturn this, but we got more than a third of the votes. We could uphold the veto by the President. They could not even get the bill up in the Senate. They could not get it through the regular legislative process.

And sometime between midnight and 7 a.m., at the behest of a few very powerful right-wing Members of the majority, this legislation overturning the will of the people of the State of Oregon was inserted into this miscellaneous tax bill. This is an outrageous abuse of legislative power.

Mr. LINDER. Mr. Speaker, I am pleased to yield 4 minutes to the gentleman from Illinois (Mr. WELLER), a member of the Committee on Ways and Means.

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

Mr. WELLER. Mr. Speaker, I rise in strong support, not only of this rule, but of this legislation. This afternoon, we are going to vote on a pretty modest package of tax relief as well as a very generous contribution of additional funding for reimbursements for Medicare. That is what this legislation contains.

So the most important provisions are provisions such as those which help working people, working families where we allow people to set aside more for retirement, more for their savings, by increasing what one contributes to their IRA from $2,000 to $5,000, if one has a 401(k), increasing it from its current level from $10,000 to $15,000, tax savings to help one save for the future.

I also note that we have special provisions which will benefit working moms. I think of my sister Pat, who does not want everybody to know, but she is over 50. She has taken a few years out of the workforce. Now she is back in the workforce, a little extra income. She can make up her missed contributions to her IRA and 401(k) she was not able to make when she was at home with the kids. That is a good provision to help working moms and working people.

I also want to point out this legislation helps the entrepreneurs, the self-employed. A lot of people have talked about it. This legislation does it. We give 100 percent deductibility for the self-employed for their health insurances. Corporations have gotten it for years. The self-employed only get 60 percent. It is time we give them 100 percent.

□ 1145

I also want to point out another large group of working folks that benefit. We repeal the section 415 limits that have penalized 10 million building trade union members, building tradesmen and people who have their pensions limited unfairly because of section 415. I think of Larry Kohr from La Salle County, Illinois, a retired laborer who currently gets about $16,000 a year. He will receive almost $30,000, what he should be receiving for his pension, thanks to this legislation. That is good for working folks.

As we work to revitalize our blighted communities, I am proud to say that we expand the low-income housing tax credit, a key initiative that Ronald Reagan signed into law that enlists the private sector to, of course, create affordable housing for working poor and low-income families. As a result of this, we will probably see another 30,000 units of affordable housing provided every year as a result of the increase from the low-income housing tax credit.

Something else that is important in the Chicago area. We have about 2,000 brownfields. These are old industrial sites. Every community has one, but we have about 2,000 in the Chicago region. Of course, because of the financial costs of the environmental cleanup, private investors are hesitant to buy that old industrial park on the side of town, so that old industrial park just sits there and blights the community. We expand the current brownfields tax incentive, which means that every community in America, whether a middle-class community, a suburban community, a rural community, or the big cities, if they have a brownfield, a private investor can fully deduct, 100 percent, the environmental cleanup costs. That will help the communities, and it is good for the environment.

Lastly, I want to point out something that is pretty important. For a lot of us, our biggest employers in town are our local hospitals, our nursing homes, our home health care. We care about health care in this House, and we want to ensure that we have quality affordable health care. Because of the way the Health Care Financing Administration has interpreted the Balanced Budget Act, they have squeezed our local hospitals, they have squeezed our local nursing homes, they have squeezed and hurt home health care. They have pushed providers out of Medicare+Choice. Because of the pressure of the Health Care Financing Administration, this Congress last year set aside an additional $16 billion to increase reimbursements for local hospitals and nursing homes as well as home health care to help our seniors and to help families.

That is good news, but I want to point out we need to do more, and I really want to salute the leadership in this House for realizing that we need to do more in Medicare. We provide $28 billion of additional reimbursements to help ensure that we provide quality health care to our local hospitals, our local nursing homes, our local home health care, and ensure that seniors have a choice in Medicare by ensuring that we have providers that get fair reimbursement for participating in Medicare+Choice.

This is good legislation. We are hearing the usual rhetoric on the other side, the partisan rhetoric. We are 12 days from election. We expect that. But this is good legislation that helps a lot of people all throughout America. It helps people save for retirement, it revitalizes communities, and ensures we have quality health care in our local communities. The bottom line is it is a good bill, and it is legislation that comes at a modest cost that will help a lot of people. I urge bipartisan support.

Mr. MOAKLEY. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. STARK).

Mr. STARK. Mr. Speaker, this rule paves the way for the cruelest hoax

that the Republicans have yet perpetrated on seniors, children, and the health care system in our country.

Forty-seven percent of this bill over 10 years goes to managed care plans without asking the managed care plans to do a thing except raise their own profits and put the money in their pockets. Ninety-four percent of the tax cuts go to people who are already insured. What does that do? That just gives the employers an incentive to cut back on insurance benefits, as they are doing every day. Sure, it helps the rich employers while it penalizes the poor employees.

Long-term care tax deductibility. Fifty percent of the seniors are living on incomes of less than $15,000 a year. What does that do for the seniors when we have ignored long-term care benefits that we should have.

Children's benefits have been dropped out of this bill. Lou Gherig benefits. Eighty-two Republicans co-sponsored a bill, along with 200 Democrats, to give improved benefits to people with Lou Gherig's disease. It was dropped out. Cruel.

Forty-seven percent going to managed care plans, where we do not have any control, where we need the Patients' Bill of Rights. What could we do with that money? We could expand the hospital aid for an additional year. We could expand hospice care for an additional year. We could withhold the 15 percent cut on home health care for an additional year. Why are we not doing that instead of giving this to the Republican friends in the managed care companies who will see nothing but their prices go up on Wall Street while they continue to deny care and deny drug benefits and fold up their tents and leave smaller communities?

Nothing in this bill will change that. It will reward the managed care plans for basically harming the beneficiaries and our seniors. That is not the way to go about this.

This is a bill constructed to help the small percentage of the rich. It is a bill purposely crafted to deny children's health benefits. Children cost $400 or $500 a year to insure. A child without health insurance is a child without health care. The Republicans take great joy in telling us we are going to deny children health benefits. That is not the kind of people we want to have running this country.

We should protest this bill to show that the Republicans have no mercy for children, no mercy for the seniors. They care nothing except for the very richest. They will deny health care if it helps the employers at the cost of the employees. Call this bill what it is. It is an arrogant play of pandering to the rich, of pandering to the wealthy at the expense of the poor and the people without health insurance.

They should be ashamed of themselves for this bill. The President will veto it, as well he should. I urge a ''no'' vote and a ''no'' on the rule.

Mr. LINDER. Mr. Speaker, I yield such time as he may consume to the gentleman from California (Mr. DREIER), and just comment that I will put the gentleman from California down as undecided.

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

Mr. DREIER. Mr. Speaker, I thank my friend for yielding me this time and congratulate him on the hard work that he has put into this measure.

Let me say that as I listened to my fellow Californian talk about this measure, it sounded as if he was disturbed over the fact that we are not moving in the direction of establishing a national health care plan. That really seems to be the goal that a number of people have, moving towards single payer.

What this bill does specifically is it provides incentives for people to plan and create more choices when it comes to the area of health care. It provides a substantial deduction for expenses related to long-term care; it provides deductibility for the purchase of long-term care insurance policies; it provides an immediate 100 percent deductibility for health insurance for the self-employed; and it provides health care deductibility for those who purchase health care outside of their employer.

The idea here is to provide a wider range of choices rather than getting the government more and more involved in the issue of health care.

Let me talk about a couple of other very important provisions in this measure, Mr. Speaker. Sitting over here is my good friend, the gentleman from Ohio (Mr. TRAFICANT). He has worked long and hard, as the gentleman from Georgia said in his opening statement, to put together a bipartisan package which I am happy to say was introduced with our now Republican colleague, another fellow colleague, the gentleman from Californian (Mr. MARTINEZ), to deal with the issue of the minimum wage.

It is clear I have not been a supporter of the Federal Government imposing a minimum wage, but I do want to say that the gentleman from Ohio (Mr. TRAFICANT) deserves a great deal of credit for the bipartisan effort that he has put into this, and I want to congratulate him for that.

I also want to say that as we look at these measures that have been mischaracterized by our friends on the other side of the aisle, I think we have to really sort of open up and look at what exactly we have here. There is nothing in here that is designed to benefit the rich. Quite frankly, I am one who is proud of doing what we can to create more incentives for those who have been successful. I make no bones about that. I am a proponent of encouraging even more people to join the investor class.

The fact is, if we look at the provisions which allow for the increase to $5,000 for contributions to individual retirement accounts, up to $15,000 for 401(k)'s, those are designed to try to help middle-income Americans who are working and want to have an opportunity to plan and save for their retirement. That is something that has enjoyed, again, very much bipartisan support here.

As I listened to my friend from Oregon a few minutes ago talking about these issues which had not passed the House, staff has just informed me as we go through this litany of items here, everything has passed through the House, most of it with strong bipartisan support.

I will tell my colleagues that when we look at the extraordinarily important measure in here, I do not know how the President could possibly consider vetoing legislation that includes this very important community renewal and the provisions that are there which are designed to go in to areas that have been devastated economically and zero out capital gains. The capital gains incentive, by zeroing it out, would encourage investment and say to those who are less fortunate that there is going to be an opportunity for them to in fact get on to that first rung of the economic ladder and pull themselves up.

That is exactly what has been put together here, again in a bipartisan way. The President has been supportive of that measure, and that is one of the bulwarks of this bill.

So here we are in the waning hours of the 106th Congress. We are hoping to complete our work today. The President can help us do that by signing this very balanced piece of legislation, which is encouraging economic growth, and is designed to help people plan and save for both retirement and their health care, it targets the inner city blighted areas so that we can encourage investment there to improve the quality of life for those who are less fortunate in this country, and it provides very important relief for the signal business sector of our economy.

It is a balanced measure. It deserves our support, as does this rule, and I urge my colleagues in a bipartisan way to vote for this measure and then to encourage the President to do the right thing and sign this bill.

Mr. MOAKLEY. Mr. Speaker, I yield 2 minutes to the gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I thank the gentleman for yielding me this time.

This bill contains a provision that would overturn Oregon's Assisted Suicide Law. Now, I appreciate the fact that we were given a whole day to debate this bill, and it was an up-and-down vote. We got enough votes if the President decided to veto it that we could uphold that veto.

On the Senate side we were told that it would not be attached to another bill; that it would be a fair fight; that, again, it would be an up-and-down vote. And here we stand today at the end of the session with a piece of legislation that contains a lot of provisions

I like in it. But I will tell my colleagues something that is more important to me. More important to me than anything else is our system of democracy. More important to me than anything else is the people's right to vote and that their voices are heard and that their vote counts for something.

In our State, not once but twice, people said we want physician-assisted suicide. Somehow or another my colleagues here seem to know better. They seem to say that they do not care about the people's vote; that it does not count; they do not care that the people's voices are not heard; they know better; they are going to overturn the people's law.

Well, let me tell my colleagues two things: one, they are overturning the will of the people of my State; and, number two, they are breaking promises. This promise was made that it would be an up-and-down vote on the Senate side; that it would not be attached to this bill. Yet here we find that happening today.

I urge my colleagues to vote ''no'' on this rule.

Mr. LINDER. Mr. Speaker, I yield 5 minutes to the gentleman from Ohio (Mr. TRAFICANT).

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

Mr. TRAFICANT. Mr. Speaker, there is no one in the House I respect more nor love more than the gentleman from Massachusetts (Mr. MOAKLEY), so I hope he will not be offended by what I have to say. I think it is time to tell it like it is.

Democrats were in power for 48 years. They did not reform welfare, they did nothing about prescription drugs, they did not reform the IRS. They would not even hold hearings on a Traficant bill that made a big difference, and I am proud of that.

Look back at the minimum wage, I think the Republicans raised the minimum wage the last two times. I support the rule, I support the conference report, and I want to thank the Republican leadership for giving me the courtesy to sit down on the minimum wage issue, so important to America and to my district.

The gentleman from California (Mr. DREIER), the chairman of the Committee on Rules, did not want a minimum wage increase.

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There are parts of this bill I do not find all that great. But the President is absolutely an expert at reconciling differences. And no one better than the Speaker and the gentleman from Florida (Mr. YOUNG) and the gentleman from Texas (Mr. ARMEY) and the gentleman from Texas (Mr. DELAY) and their staff, the gentleman from Georgia (Mr. LINDER), they have gone to them. And his statement is for the betterment of America. Let us find common ground. Mr. President, let us find the time to find common ground.

There is pension reform in this bill. The earned income tax provisions are good. Let us get off the class warfare on the tax cuts. My colleagues, what good is the minimum wage of $1 an hour over 2 years if the boss cannot afford it and lays off the very people we are trying to help the most? Give the boss a break.

The Republicans are right. How much more of this Democrat versus Republicans, liberals versus conservatives? It may be good for politics or for winning the majority, but it is bad for America because it ends up being rich versus poor, men versus women, old versus young, black versus white, ''the haves'' versus ''the have-nots.'' If there is no company, there is no job.

Let us get off it. This is nothing but political machinations to who is going to run this place. The American people want this conference report. They may not like all of it, but they know we have the leadership in the gentleman from Florida (Mr. YOUNG) to sit down with the President and work it out, for the Speaker to sit down and to make those compromises that are necessary.

I would just like to close by saying this: It is time to close the Congress. It is time to pass this conference report. And for those Democrats who are going to come out here for partisan reasons and vote against this bill, they may encourage the President to veto it, but, in my opinion, they are not vetoing a bad bill, they are vetoing a bill that is good for the American people.

Mr. MOAKLEY. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentleman from Massachusetts (Mr. MOAKLEY) very much for yielding me the time.

I am very delighted to follow my colleague because I know his sincerity. I do not think any of us want to divide black or white or brown, we do not want to divide Americans. But I believe what we want to do is to say to America we accept the challenge to do better.

I want this rule defeated so that we can go back to the drawing board and do better. And the reason why I say that is because I have lived the experience of hospitals being closed in Texas.

Some 10 to 15 years ago, the Attorney General of the State of Texas appointed me to an advisory committee to explain and to advise how we could restore rural health centers and rural hospitals. In Texas they were closing even then. I would imagine that Americans would tell me about hospitals that closed 20 years ago, 5 years ago, 10 years ago, or yesterday. What a tragedy for communities that have to travel miles away from their neighbors to get health care.

And so, this rule should be defeated, Mr. Speaker, because $11 billion goes to insurance companies. I am crying out for my rural and urban hospitals, public hospitals where they take their children, where they take their old mother or father, their aunts or their neighbor. Why am I giving $11 billion to insurance companies and doors of my hospitals still closing? I want my hospital CEOs in my district who know that I have been on the front line on this issue to understand why I want this rule defeated.

Mr. Speaker, we can do better for Americans. Do not give this money to the HMOs. They are not guaranteeing any guaranteed prescription drug benefit. In fact, one of the HMOs said, it is really hard to enhance our drug benefit for seniors. They do not want to work on this problem. We need this money going directly to the providers.

And what is happening to the home health care centers? They are getting zero, no money. And if any of my colleagues have dealt with them, they know that many of their relatives prefer going to those home health care centers that give them personalized treatment.

We can do better for America united. Do not divide us. Send this rule back and defeat this bill.

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

Mr. MOAKLEY. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I want to stress that my opposition to the rule and this bill is not based on any ideology or any politics, Democrat or Republican. The problem here is that this bill is not going to help the average American. And that is what we are all concerned about, and we are all united to try to help the average guy.

I heard the chairman of the Committee on Rules say that he supports this bill because it is going to help the investor class or get more people in the investor class. Well, let me tell my colleagues, if I am a person that does not have health insurance and I am not getting it through my employer, I am the little guy, I am not going to be able to take advantage of whatever tax deduction is in here to buy health insurance and to get myself an insurance policy. It is not going to happen.

The bottom line is that we know that the reason why most people do not have health insurance today who are employed is because the employers do not provide the insurance.

There is a disincentive with this above-the-line health insurance deduction for the employer to continue or to expand health insurance for their employees. So we are going to have more people join the ranks of the uninsured. This notion that somehow they are going to be able to take this deduction and buy health insurance is a lot of garbage. It is not going to happen.

Secondly, let me talk about the hospitals that are suffering. I had a hospital in my district that closed and others that have the potential to close because they are not getting enough

money from Medicare from the Federal Government.

Do not tell me that we are going to give this money to the HMOs, something like 40 percent of the funds, and we are not going to help our hospitals, our home health care agencies, our nursing homes. Many of them are bankrupt and closing. If we are going to do anything to help with the reimbursement rate, it should be to those providers, the hospitals, so they do not close.

What about the HMOs? The HMOs that are benefiting from this bill are having no strings attached to the extra money that they are getting. They do not have to stay in the Medicare program. And many of them have moved out of it. Something like 700,000 seniors who were in HMOs have been dropped by HMOs in the last couple years. So no strings attached. They get the money. They do not have to stay in the Medicare program.

Nor do they have to do anything about their benefits. They do not have to guarantee they are going to provide prescription drugs. They do not have to do anything to increase the benefits.

The HMOs are getting a sweetheart deal, and they are doing nothing for the American people in return. Vote against this rule. Vote against this bill. It does not help the average guy. Forget the ideology. It does not help the average American.

Mr. MOAKLEY. Mr. Speaker, I am very happy to yield 2 minutes to the gentleman from Michigan (Mr. LEVIN).

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

Mr. LEVIN. Mr. Speaker, this bill and this rule are useful in one sense, and that is that it really shows what the majority is all about. Truly, it makes a mockery of all the talk about bipartisanship. There was not, in the last 24 hours, I think, 1 minute of discussion between the majority leadership and the minority leadership. There was no effort to dialogue with the administration. Instead, I guess the majority thought they would put together a stew of the bad and the good and try to get this through.

There has been a lot of talk about compassion in this campaign. This makes a mockery out of the talk on the majority side about compassion. They delete provisions regarding pregnant women and children. They delete the provision for people with Lou Gehrig's disease, just among a couple of important aspects of this.

And then, look, hospitals in my district, many of them are in trouble. And so what they do is hand a bundle, 40 percent, to HMOs and they shortchange the hospitals that really need it.

Whose side are they on?

So they want a Presidential veto. I would have thought they would have learned by now. They are going to get one. The President will get on the bully pulpit, as he can do so well, and tell America what this bill is all about. And I hope he takes that pulpit all around this country. Because this puts in place what Republicans are really all about.

Halloween, it unmasks their efforts on compassion. It takes the mask off all of this talk about bipartisanship. This is a totally partisan effort on their part, and I think it will not pay them dividends on November 7 and it will hurt the American people.

Mr. LINDER. Mr. Speaker, I yield 3 minutes to the gentleman from Minnesota (Mr. GUTKNECHT).

Mr. GUTKNECHT. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I was not going to speak on this. But listening to some of this heated rhetoric, I really feel compelled to respond.

I cannot really understand why these people are so opposed to this bill. In fact, we heard our colleague from New Jersey just a few moments ago say that this would not work.

I have to ask, what are we afraid of? What is wrong with allowing 100 percent deductibility for health insurance for the self-employed? I mean, as far as I am concerned, this Congress should have done that a long time ago.

Look at the other provisions in this bill. Now, I must tell my colleagues that I am not a big fan of some of these omnibus bills and putting a lot of things that may not be related into the same bills. But the truth of the matter is, as I look through the provisions of this bill, virtually every one of them is going to benefit somebody.

Now, we do not have many HMOs in my district. I would like to have HMOs. I would like to give people more choices. Now, we can argue whether too much went to this particular group and too much went to the other. There is no such thing as a perfect balance. But I think, on balance, this is a very good bill. This does a lot of things for an awful lot of people. I think the hospitals, the nursing homes, the people back in my district are going to be very happy with this bill.

Now, how we got into this mess we can all debate about. But this is the right thing to do. And I have to ask my colleagues, what are they afraid of? What is it in this bill that somehow is going to make matters worse for people who need health care, for people who need to go to nursing homes, for people who want to deduct their health insurance premiums, for those people who want to make larger contributions to their IRAs.

I mean, with the long list of good things that is in this bill, I am somewhat surprised at the incredibly heated rhetoric that we are hearing on this rule.

So I stand in strong support of this rule and in support of the underlying bill.

Mr. MOAKLEY. Mr. Speaker, it gives me great pleasure to yield 5 minutes to the gentleman from Missouri (Mr. GEPHARDT), the Democratic leader of the House.

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

Mr. GEPHARDT. Mr. Speaker, I rise in strong opposition to a Republican tax package that reflects this Congress at its worst. This package reveals the larger flaws of the Republican tax philosophy that have been on exhibit over these past years, really a 6-year attempt to give tax cuts to people and institutions that do not need them and not giving tax relief to people and institutions that need tax relief.

First, there is nothing in this bill that guarantees a single new school will be built. The only thing we have had from Republicans is a consistent effort to fuzz the issue of who is for school construction and who is against it.

Two days ago, Republican leaders rejected the bipartisan Johnson-Rangel bill supported by 228 Members, Democrats and Republicans, to help districts with school construction; and they came up with a different plan that was a day late and a dollar short.

The largest part of that plan creates incentives that we think actually delay school construction, and half the benefit does not even go to school districts but to bondholders, private investors, not children, not principals, not teachers, but bondholders.

□ 1215

This is a typical ploy, part of an effort to fool people into thinking that they support education. This has become an exercise in illusion.

They put forward school construction provisions that bear resemblance to Democratic and bipartisan bills in name only. They trudge to the Capitol and hold press conferences a few hours ago and talk about middle-class fairness when nothing could be farther from the truth. We call on the leadership to bring up the bipartisan school construction measure to help modernize our schools in the Labor-HHS-Education bill. The Johnson-Rangel bill reduces the burden on local taxpayers struggling to finance new school construction in their communities. We further urge the leadership to set aside their opposition and drop the tax cuts that really do not perform a useful function. They should provide enough funding for teachers, emergency school repairs, after-school programs, teacher training and put all of these measures in the Labor-HHS-Education bill so that the President can sign a bill that improves our schools this year in all of these ways.

This package is just as flawed on the health care side. After blocking an effective Patients' Bill of Rights, an effective prescription drug benefit under Medicare, now Republicans come forward with a package that does not help the vast majority of Americans or square with the needs of working families. The BBA piece does not do enough for people and hospitals and gives too much for HMOs. Their deductions will

not substantially reduce the number of Americans without health insurance, they weaken employer-based health coverage, and they do virtually nothing for families who provide their own long-term care.

We support restoring cuts to Medicare. We want tax relief. In fact, the President and Democrats have put forward a sensible bill that helps fix the problems for providers and beneficiaries in Medicare and Medicaid and gives relief to families and hospitals that truly need it. But Republicans choose to go behind closed doors and not tell us what is in their tax package until a few hours before it comes on the floor. They choose the path of conflict, not consensus. Dictation, not dialogue.

Well, the President is going to veto this bill; and we are going to be right back here where we started passing more CRs because we were unable to do the work of working with one another to get the job done. The package we reject today reflects the larger problems with misplaced priorities, misplaced tax cuts, and raids on Social Security.

Just today, a nonpartisan group of financial experts predicted that Governor Bush could not cut taxes and divert Social Security payroll taxes without blowing a huge hole in the budget. The Nation's best economists and actuaries found that by 2015, Governor Bush's plan would return us to the days of big deficits. His plan would undermine Social Security, and we would be headed right back to where we were in a sea of red ink in the 1980s. This makes clear that the Bush plan would weaken Social Security and ruin fiscal discipline.

So we are not getting our work done. We are not hiring a single new teacher. We are not improving a single new school building. We have not spent a dime on quality teaching and after-school programs. We need to make the passion and purpose of this Congress in its closing days our children, our public schools, our teachers, our parents, our children, making sure that every child in this society is a productive, law-abiding citizen. We are now going to have to pass a new CR every day because we are behind in our work. Let us get to work together to find a consensus to get these things done and get them done in the next 2 days.

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

I am confused. I was sent down here to discuss the rule on a tax bill, and we have just debated the Bush-Gore presidential race. I am glad he got the time to do it because it shows that those folks in charge for 8 years did not get any of the things done that he wanted done.

POINT OF ORDER

Mr. RANGEL. Point of order, Mr. Speaker.

The SPEAKER pro tempore (Mr. BURR of North Carolina). The gentleman will state his point of order.

Mr. RANGEL. Mr. Speaker, I would ask the Parliamentarian whether it is within the rules of this House for a person to discuss the presidential campaign in the course of our legislative debate.

The SPEAKER pro tempore. All Members should conform their remarks to the pending legislation.

Mr. LINDER. I do believe that is a point I was making after the gentleman from Missouri (Mr. GEPHARDT) spoke that he did nothing but speak about the presidential race.

Mr. Speaker, I am happy to yield 5 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Speaker, I rise in support of the rule, and I regret to say that I think it is a sad day on this House floor when the minority leader confuses issues so completely as to mislead the American public. For him to say there is not one penny in this bill for teacher training or after-school care, is misleading. Those things are in the appropriations bill. That is, in the health and human services appropriations bill, and we will discuss that tomorrow; and I am proud that in that bill there is more money for public education than the President asked for. It is a good bill. But we will talk about that tomorrow.

This is a tax bill. Of course it does not appropriate dollars for those purposes. I am very proud that in this bill we move from $400 million for school construction to almost $16 billion to help our towns and cities construct and modernize their schools. Is it my bill and the gentleman from New York's bill, which I thought was the best bill? No, it is not exactly. But it does apportion the money the way we did in our bill, and it does put lots more money out there. And yes, the money goes directly to the cities.

So to pretend that there is no help for our towns and cities is misleading. It may not be the $25 billion I wanted or exactly the bill I thought was a better distribution mechanism and I certainly do think the bill that the gentleman from New York and I worked out was the best. Nonetheless, this bill does increase school construction funding dramatically, more than any other year and more than any year when the Democrats were in total control of this House and the Senate. This is a great leap forward for our towns and cities.

Let us look at Medicare. The Medicare section is far more money, by about a third, than the President proposed only a few weeks ago. The hospitals are going to benefit. The home health care agencies are going to benefit. The nursing homes are going to benefit. And frankly they are desperate for that help. I would certainly hope that the President does not veto this when it not only provides more money for Medicare providers than he proposed, but also a bill of rights for Medicare recipients that participate in Medicare+Choice plans. We have been trying to do this for ages. The average appeal time for a Medicare recipient appealing a denial of care under Medicare is 500-plus days if it is in one part of Medicare and almost 300 days in the other part. Yes, I am sorry we did not do a Patients' Bill of Rights for people under 65. But let us do Medicare Patients bill of Rights and add-backs so the providers will flourish and be able to provide care not only to our seniors but our community hospitals will survive to provide care to everyone.

Let us also remember that this is a great step forward in providing patient rights for seniors under Medicare+Choice. So maybe it is not everything the President wants. He was not very clear about that. His only objection was in the managed care plus choice plans where he said we were doing too much. We are only doing 3 percent. That is less than we are doing for hospitals, less than we are doing for other providers, and those managed care choice plans are providing more for my low-income severely ill seniors than Medicare is. That is why they like them.

I am hearing more about the anguish and fear of my seniors who are losing their managed care choice plans than I am about their desire for prescription drugs. They want prescription drugs, but they are panicked because they are losing their managed care choice plans. And they are not even eligible for MediGap coverage. They either cannot afford it, or they are excluded for preexisting conditions. So while the President says 3 percent is too much, it is less than we are giving anybody else, and these plans, until we modernize Medicare and make it a better program for all, these plans must be kept alive because they are providing crucial care for very poor and ill elderly.

And you know who is going under next? It just amazes me. The next group of plans to pull out are the group that serves New York City and the suburbs. It is the densely populated areas where any plans are surviving at all. They are the next to go out. Mark my words, because we are only doing 3 percent, our seniors in those areas are going to suffer.

I want to say one other thing about the tax provisions. As I walk through the factories in my district, the small factories where the factory owner is not able to provide 100 percent of the premiums for health care, the employees at the machines, the workers, are carrying 50 percent of their premiums. They will be able to deduct this cost under this bill. The high earners already get full medical care, and the company takes the deduction for their premium. This is about the little guy who either has to pay his own premium or 50 percent of his premium.

This is a good bill. It goes to the heart of working men's needs and working women's needs for health care, for opportunities for pension savings, for jobs in our most debilitated urban areas and for Medicare for our seniors. Maybe it is not everything the President wants, but there is not anything in here that most Members have not already voted for. Do not let the politics

of the presidential race be the enemy of progress for working people in America.

PARLIAMENTARY INQUIRY

Mr. MOAKLEY. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. MOAKLEY. Mr. Speaker, is it proper for a Member to say that a Member is misleading the public by a statement he makes here on the floor?

The SPEAKER pro tempore. The rules of decorum in debate prohibit any descent to personalities.

Mr. MOAKLEY. So it is not in order for a Member to say that a Member intentionally misled someone by his statements?

The SPEAKER pro tempore. If it is an accusation of deceit, the gentleman is correct.

PARLIAMENTARY INQUIRY

Mr. LINDER. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. LINDER. Mr. Speaker, if a speaker on the floor makes a statement that is incorrect and someone corrects the statement, such as there is no money in here for school construction and in fact there is $15 billion, is that a statement of derision against the speaker or a correction of facts?

The SPEAKER pro tempore. The rules of the House would distinguish between deceit and mistake.

Mr. MOAKLEY. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. RANGEL), the ranking member of the Committee on Ways and Means.

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

Mr. RANGEL. Mr. Speaker, I am glad that the gentlewoman from Connecticut is on the floor with all of her candor. I would ask the gentlewoman from Connecticut to pay particular attention to what I am saying so that she might take down my words if they appear to mislead. Because I know that the President of these United States has written to the Republican leadership to say basically, Can we talk? Can we talk taxes? Can we talk about a $250 billion tax cut over 10 years?

I know that. I also know that the Republican leadership, rather than take these tax issues to the United States Congress, rather than take them to the House of Representatives, rather than take them to the committee which the gentlewoman from Connecticut and I are privileged to serve, sought not to take it to the Committee on Ways and Means. I would think the best way to deal with this is to leave the floor because the deception that is going on here today is that most people thought that when we adjourned yesterday, we adjourned yesterday.

I want my words taken down to say that it is a fraud on the American people to say that we adjourned yesterday 8 o'clock this morning in order to trick the American people into believing that yesterday is today. If you want to take my words down, we will go to the Parliamentarian and ask does that make any sense.

Does it make any sense to have a tax bill not come out of the tax committee? How dare them think that is what is best. The gentlewoman from Connecticut said that she and I had come to a state of mind in terms of a bill that has 230 cosponsors as to how we can modernize and how we can construct new schools.

□ 1230

Would Republican leadership talk with Democrats about how we could work out something, like the gentlewoman from Connecticut (Mrs. JOHNSON) and I have worked out? Would they call the White House and ask whether or not they can work out something?

For whatever reason, the Republicans are looking for a train wreck. They are asking for a veto, because each and every thing that the President has asked for they gave it to him, but put in a poison pill with each and every one of those things.

Sure, we want to improve the Medicaid and Medicare bill and give it back. Why is it you leave out hospitals and put in HMOs? There are things we can do, not as Democrats, not as Republicans, but as Members of Congress.

All of a sudden we are supposed to go home now and say we do not need the Congress. A handful of Republicans can ignore the President; a handful of Republicans. They do not go to the Republican committee members, they do not go to their Democrat counterparts, they do not go to the President of the United States. They just figure that they are going to get out of here and just are going to bring anything to the floor.

Well, it is not going to work that way. If we want to get out of here with some semblance of mutual respect, if we want to give credibility to the House of Representatives, we have to respect our committee system, and no one is going to tell us what to do and what to vote for and what to pass, and the President reserves the right to veto.

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

Mr. Speaker, I would just like to make note that the letter the President sent us after we had passed this original bill in the spring of this year, the letter he sent us that asked could we sit down and talk about taxes, arrived yesterday.

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

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the gentleman from Mississippi (Mr. TAYLOR).

Mr. TAYLOR of Mississippi. Mr. Speaker, the citizens of America entrust us with running their Nation. We are going to be asked in less than 3 hours to vote on a 960-page document that was just delivered to the House. No one knows what is in it. There could be a tax on handguns; there could be a tax on cigarettes; they could bring back prohibition. Neither the Speaker of the House nor the gentleman from Georgia (Mr. LINDER) have any idea what is in this bill. But if the House votes for it and the Senate votes for it, it becomes the law of the land, until it is repealed. That could take 1 year, that could take 100 years.

This Nation squanders $1 billion on interest on the debt. I hear my Republican colleagues say we finally turned a profit. We have an $8 billion surplus for the first time in 30 years. I would tell you that surplus compared to the debt is like a person who, for 30 years, has been charging things to his Visa card and finally breaks even at the end of 1 year and has $1,000 left, and says, ''Honey, let's go blow it,'' ignoring the fact that he is $686,000 in debt on his credit cards. That is the comparison of this year's surplus to the accumulated debt of $5.7 trillion.

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Mr. Speaker, I appreciate the gentleman's courtesy.

Would that the rule that we are debating here today simply had given us a tax bill that somebody may be able to comprehend. As my colleague from Mississippi pointed out, there is nobody in this Chamber that knows exactly what they are voting on.

I look forward to the debate later today on the merits of the proposals that we have heard argued briefly before us. But this rule snuck in provisions that are extraneous to taxation.

I give you just one example: It does not just overturn Oregon's death with dignity law, the only such provision in the United States, but it would criminalize the critical doctor-patient relationship dealing with the management of pain.

This is something that is objected to by a number of medical societies around the country. Any thinking professional who considers the potential of criminalizing this sensitive relationship understands on this basis alone it calls for the rejection of the rule and the underlying bill.

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

Mr. Speaker, I urge a no vote on the previous question. Only by defeating the previous question will the House be allowed to vote on the Democratic alternative.

Our plan would include an increase in the minimum wage. Our plan would include targeted tax credits. It would provide $25 billion in real school construction and modernization financing with the prevailing wage protections. Our plan would improve Medicare, Medicaid, children's health benefits, and would include many, many other items.

Mr. Speaker, I include for the RECORD the text of my amendment.

PREVIOUS QUESTION AMENDMENT CONFERENCE REPORT ON THE SMALL BUSINESS INVESTMENT ACT

At the end of the resolution insert the following;

''Sec. 2. Upon adoption of this resolution, the House shall be considered to have adopted a concurrent resolution introduced by Representative Gephardt on October 26, 2000, directing the Clerk of the House of Representatives to make corrections in the enrollment of the conference report on H.R. 2614 to amend the Small Business Investment Act to make improvements to the certified development company program, and for other purposes. The concurrent resolution deemed to have been adopted by the House shall consist of the Democratic alternative to the conference report including an increase in the minimum wage, targeted tax relief—including $25 billion in real school construction and modernization financing with prevailing wage protections—and Medicare, Medicaid and SCHIP benefit improvements and protections, and other matter.

Mr. Speaker, I yield back the balance of my time.

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

Mr. Speaker, I include for the RECORD a list of 40 or 50 health care organizations, from the Federation of American Hospitals, American Cancer Society, et cetera, who are in support of this bill and the provisions in it.

FEDERATION OF AMERICAN HOSPITALS,
Washington, DC, October 19, 2000.

Hon. DENNIS HASTERT,
Speaker of the U.S. House of Representatives, Washington, DC.

Hon. TRENT LOTT,
Majority Leader of the U.S. Senate, Washington, DC.

DEAR LEADER(s): On behalf of the nation's 1,700 privately-owned and managed hospitals, the Federation of American Hospitals is pleased to offer its strong support of the Medicare, Medicaid & S-CHIP Beneficiary Improvement & Protection Act of 2000. In the wake of the unintentionally negative impact of the Balanced Budget Act of 1997 (BBA), hospitals and health providers across the country have struggled financially, straining their ability to provide quality patient services. This legislation is a major step toward addressing some of the excesses in the BBA, and restoring stability to our health care delivery system.

By providing hospitals with a full inflation update for fiscal year 2001, Congress will allow us to be better prepared to meet the costs of delivering care to the millions of patients that we annually serve. By addressing excessive reductions in Medicaid, in Medicare Disproportionate Share payments, and in payments for indigent care, the bill targets its assistance at the precise payment policies that have so negatively impacted hospitals in recent years. Would hospitals like more relief, for a longer duration, including the restoration of our full inflation update for 2002? Certainly, but we appreciate the significant assistance of this bill. Above all, we want to ensure that the relief that is included in this package becomes low before Congress adjourns.

In addition to the broader provisions that impact all hospitals, the bill also includes significant provisions to assist rural hospitals, hundreds of whom are Federation members. Among numerous important rural provisions, the changes to the Medicare DSH program thresholds that will allow far more rural hospitals to participate, may be the most important. Many struggling hospitals in rural communities, serving predominantly low-income populations, will receive vital new assistance that will allow them to maintain services to poor Medicare patients.

Finally, this summer, after many years of development, hospitals moved to outpatient prospective payment (PPS). Despite improvements under the new outpatient PPS, beneficiary copayments remain high for some services due to historical design flaws in the program. This bill will significantly reduce many of those copayments, lowering costs to seniors.

These are just a few of the many positive provisions that have been included in this legislation to help patients and their health care providers. As a result, the Federation strongly supports the Medicare, Medicaid & S-CHIP Beneficiary Improvement & Protection Act of 2000. We will work with Congress and the President to encourage its swift enactment.

We look forward to working with Congress and the Administration to further educate our leaders on the difficulties facing our health providers. Both the President and Congress have shown a significant appreciation for the reimbursement problems facing our hospitals, and we hope that we can continue this dialogue. Only with a sustained bipartisan dialogue can our hospitals, and our biggest insurer—the government—continue to provide the world's finest health care in an increasingly complex fiscal environment.

Sincerely,

THOMAS A. SCULLY,
President & CEO.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.,
Washington, DC, October 18, 2000.

Hon. TRENT LOTT,
Majority Leader, U.S. Senate, United States Capitol Building, Washington, DC.

Hon. J. DENNIS HASTERT,
Speaker, U.S. House of Representatives, United States Capitol Building, Washington, DC.

DEAR MAJORITY LEADER LOTT AND SPEAKER HASTERT: On behalf of the National Association of Community Health Centers (NACHC), thank you for your efforts to protect health care access for more than 11.5 million medically underserved Americans by including the Medicaid prospective payment system for Federally qualified health centers in the final version of BBA relief legislation.

As you know, the BBA eliminated a fundamental underpinning of America's health center safety net by phasing-out and eventually terminating the Medicaid cost-based reimbursement system for Federally qualified health centers. Health centers believe that your efforts to include a new prospective payment system for health centers in your BBA relief legislation is essential to their continued survival and will ensure that they remain a viable part of America's health care safety net.

Thank you again for your commitment to protecting health centers through your BBA relief legislation. Enactment of this prospective payment system is essential to protect the struggling health care safety net and will ensure the place of health centers in providing access to care for millions of uninsured Americans. We stand ready to work with you to make meaningful BBA relief for health centers a reality.

Please feel free to contact me if there is anything that I can do for you.

Sincerely,

THOMAS J. VAN COVERDEN,
President and CEO.

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION,
Washington, DC, October 19, 2000.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Finance, Dirksen Senate Office Building, Washington, DC.

DEAR CHAIRMAN ROTH: The American Medical Rehabilitation Providers Association (AMRPA) thanks you for your leadership in securing passage of the ''Medicare Medicaid and SCHIP Beneficiary Protection Improvement Act of 2000.'' This legislation will provide crucial and immediate relief to Medicare providers adversely affected by cuts imposed by the Balanced Budget Act of 1997 (BBA 97). We strongly support its immediate passage.

In particular, we would like to thank you for ensuring inclusion of two provisions addressing concerns of the rehabilitation hospital industry. Section 305 of the Act will eliminate, for FY 2002, a two percent cut on overall rehabilitation spending imposed by BBA 97. This provision will help shore up the financial strength of the industry as we begin the transition to a prospective payment system (PPS). Section 305 of the Act also gives rehabilitation facilities which are ready to proceed immediately to full PPS reimbursement the opportunity to do so, rather than requiring them to gradually transition over a two-year period as in BBA 97. Fully funding this provision helps to ensure the ability of rehabilitation providers to provide high quality, cost-effective care during the PPS transition.

As indicated in MedPac's June 1999 report citing the decrease in rehabilitation hospital margins to 1.8%, rehabilitation hospitals nationwide have been hurt substantially by funding cuts under the Balanced Budget Act of 1997. If additional funding becomes available for short-term relief for providers, we respectfully request that you consider making the 2% restoration effective July 1, 2001 and extending the psych hospital provision in Section 306 to include rehabilitation hospitals and units.

Please know that your leadership is appreciated by the rehabilitation hospital industry, and by hundreds of thousands of rehabilitation patients served by rehabilitation hospitals nationwide. We hope we can count on Congressional intervention for future additional financial relief for rehabilitation hospitals. Thank you again.

Sincerely,

EDWARD A. ECKENHOFF,
Chairman.

HEALTH SOUTH,
Birmingham, AL, October 19, 2000.

Hon. JIM MCCRERY,
U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE MCCRERY: Please accept this as my sincere thanks and appreciation for all of your efforts with the ''Medicare Refinement and Benefits Improvement Act of 2000.'' It is because of men such as yourself that give their attention to matters of concern to all people that we are able to make progress in much needed areas.

Rehabilitation hospitals across the nation will benefit from this legislation but greater still will be the benefit to the patients. Your help and continued support of this issue is again deeply appreciated.

Best regards,

RICHARD M. SCRUSHY,
Chairman of the Board & Chief Executive Officer.

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS,
Stoughton, MA, October 19, 2000.

Via Facsimile Only

Hon. WILLIAM M. THOMAS,
Chairman, Committee on House Administration, Longworth House Office Building, Washington, DC.

Hon. WILLIAM V. ROTH, Jr.,
Senator, Hart Senate Office Building, Washington, DC.

Hon. MICHAEL BILIRAKIS,
Representative, Rayburn House Office Building, Washington, DC.

DEAR CHAIRMAN THOMAS, SENATOR ROTH AND REPRESENTATIVE BILIRAKIS: I am writing you in my capacity as President of the National Association of Long Term Hospitals (''NALTH'') to express the strongest possible support for Medicare program and payment refinements which are presently pending before Congress. Long term hospitals are particularly dependent on Medicare program policy. Typically 60% to 70% of all patients admitted for inpatient services in long term hospitals are Medicare beneficiaries. These individuals constitute perhaps the most profoundly ill and disabled segment of Medicare beneficiaries since they all require an atypically long hospital stay and specialized programs of care.

Congressional proposals relating to long term hospitals implement long standing bipartisan recommendations of policy makers to achieve the development of a long term hospital prospective payment system and, in the interim, to equalize the payment system. These payment and policy changes are desperately needed in order to support the multitude of programs and dedicated personnel who serve this very vulnerable Medicare population.

I wish to underscore that the failure to implement these provisions, at this time in light of past reductions of payments to long term hospitals, would have an immediate and direct adverse affect on hospital employees and programs.

NALTH is appreciative of the thoughtful approach which Congress has taken on these issues and is mindful that it is important that the entire hospital industry achieve a baseline of economic health in order to support the continuum of care which is so important to Medicare beneficiaries.

We believe it is important that the President assume a leadership role with his colleagues in Congress and approve all Medicare refinements proposed by Congress.

I wish to thank members of Congress for all of their efforts to secure and improve the Medicare program with this very important legislation.

Sincerely,

GERALDINE BRUECKNER,
President.

ACUTE LONG TERM HOSPITAL ASSOCIATION,
Alexandria, VA, October 19, 2000.

Hon. JIM MCCRERY,
U.S. House of Representatives, Washington, DC.

DEAR REPRESENTATIVE MCCRERY: On behalf of the nearly 100 hospital-members of the Acute Long Term Hospital Association (ALTHA), I would like to express our sincerest gratitude for your leadership and commitment toward ensuring final passage of the Medicare Refinement and Benefits Improvement Act of 2000. We are particularly grateful for your strong efforts to secure inclusion of the following provisions: Sec. 210, which increases potential reimbursements and requires HCFA to develop a workable PPS system by October 1, 2002, and ensures that long term care hospitals, and only long term care hospitals (as defined by law) will be eligible for reimbursement under the new system; Sec. 404, which imposes a 2 grandfather clause on HCFA's pending provider-based status rule, and substitutes HCFA's ''75/75 zip code'' scheme with a more reasonable 35-mile zone provision; and Sec. 202, which increases reimbursement for bad debt.

Please do all you can to ensure these provisions remain and the bill is passed into law in this session of Congress. Once again, we greatly appreciate your leadership and strong efforts on behalf of our patients and our hospitals.

Sincerely,

S. BRADLEY TRAVERSE,
Executive Director.

NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS,
Alexandria, VA, October 19, 2000.

Hon. WILLIAM M. THOMAS,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: On behalf of the National Association of Children's Hospitals (N.A.C.H.), I am writing to thank you for your recognition of the different financial circumstances of children's hospitals and your efforts to address their concerns with the Medicare outpatient prospective payment system (OPPS).

In particular, we appreciate the inclusion of a change in the application of the Medicare OPPS to children's hospitals in both the Ways and Means Health Subcommittee's ''Medicare Benefit and Improvement Act'' and the consolidated legislation you are developing to amend those health related provisions of the ''Balanced Budget Act of 1997,'' which threaten to jeopardize the financial stability of different health care providers. Your proposal will treat children's hospitals the same as cancer hospitals for purposes of Medicare OPPS implementation, which will ensure that children's hospitals are effectively held financially harmless.

This legislative action is important to take into account the disproportionately large adverse effect that the Medicare OPPS could have on children's hospitals' ability to serve those children who qualify for Medicare. It is even more important to demonstrate to other payers of health care, which seek to model their reimbursement systems on Medicare's, that without adjustment, the adoption of the OPPS system used by Medicare can put children's hospitals at financial risk and would be inappropriate.

Any change in outpatient reimbursement methodology, such as the new Medicare OPPS, which does not reflect children's unique health care needs, can significantly affect children's hospitals' fiscal health overall, because the volume of outpatient care they provide is substantial and the greatest growth in their patient care is in outpatient services. For example, on average in FY 1998, a typical large freestanding children's acute care hospital provided care for children in more than 220,000 outpatient visits, eight percent more than in FY 1997.

Thank you again for focusing on the unique outpatient needs of children's hospitals.

Sincerely,

PETERS D. WILLSON,
Vice President for Public Policy.

KENNEDY KRIEGER INSTITUTE,
Baltimore, MD, October 19, 2000.

Hon. WILLIAM ROTH,
Chairman, Senate Finance Committee, Dirksen Senate Office Building, Washington, DC.

DEAR CHAIRMAN ROTH: On behalf of Kennedy-Krieger, a unique children's hospital which addresses the needs of children with severe disabilities, we are expressing our enthusiastic support for the conference report on the Medicare and Medicaid refinements legislation.

Included in the bill is a provision which treats children's hospitals in the same manner as cancer hospitals with respect to the Medicare hospital outpatient prospective payment system (OPPS). This provision will be of great assistance to us as we work to serve out community by performing at the highest level while providing the greatest value possible for those children who obtain services through the Medicare program.

We respectfully request that this provision become law this year, and we are grateful for your efforts.

Sincerely,

GARY GOLDSTEIN, M.D.,
President.

RURAL HEALTH CLINICS,
Washington, DC, October 18, 2000.

Hon. DENNY HASTERT,
Speaker of the House, House of Representatives, Washington, DC.

Hon. TRENT LOTT,
Majority Leader, U.S. Senate, Washington, DC.

DEAR SPEAKER HASTERT AND MAJORITY LEADER LOTT: This letter is written in support of the agreement you have reached on Medicare and Medicaid refinements legislation. As you know, this bill makes a number of important changes that will greatly enhance the ability of Rural Health Clinics to continue to deliver high-quality, cost-effective health care in underserved rural communities. We are particularly pleased that you have included the language of the Safety Net Preservation Act of 1999.

We are urging you colleagues in the House and Senate to support your package of changes and we are also asking President Clinton to support this package as well. We believe it is extremely important that Congress and President Clinton act on your proposal as quickly as possible. As you know, Rural Health Clinics are particularly vulnerable to the adverse effects of low Medicaid payments and your proposal ensures that Medicaid payments for RHC services are predictable and adequate.

This legislation represents a major improvement in the Medicare and Medicaid programs for both providers and beneficiaries. Your hard work and dedication to improving access to care for underserved population is is greatly appreciated.

Sincerely,

BILL FINERFROCK,
Executive Director.

NATIONAL ASSOCIATION OF URBAN CRITICAL ACCESS HOSPITALS,
Washington, DC, October 19, 2000.

Hon. THOMAS BLILEY, Jr.
Chairman, House Commerce Committee, Washington, DC.

DEAR CHAIRMAN BLILEY: On behalf of the National Association of Urban Critical Access Hospitals (NAUCAH), I would like to thank you for this opportunity to comment on your agreement on the Medicare and Medicaid Refinement legislation. We are appreciative of congressional efforts to restore funding for hospitals significantly impacted by the Balanced Budget Act of 1997 (BBA). NAUCAH supports several of the provisions contained in this restoration package aimed at providing additional relief from the devastating impact of the BAA for hospitals that treat a large number of low-income seniors.

NAUCAH is a nationwide coalition of private, non-profit, large urban hospitals that treat a significant number of Medicare and Medicaid patients. Approximately 275 hospitals in the U.S. today meet these criteria. Urban critical access hospitals are very much a part of the health care safety net in

the U.S. today. In most communities in which they are located, they are the primary sources of care for the urban elderly and poor, if not the only source.

Because of our significant number of low-income seniors, the impact of the BBA Bad Debt reduction, the Medicare Disproportionate Share Payments reductions, and Medicaid Disproportionate Share Hospital limit reductions is particularly burdensome on NAUCAH hospitals. NAUCAH hospitals rely on these payments for their survival.

NAUCAH strongly supports the provision in your restoration package, which provides for the immediate restoration of Medicare bad debt reimbursement from 55 percent to 70 percent. NAUCAH hospitals, by definition, treat a large number of low-income seniors who are the poorest and often sickest of the elderly. Low-income seniors, at or near the poverty level, are the most likely Medicare beneficiaries to be unable to pay their co-payments and deductibles. Consequently, NAUCAH hospitals have higher proportions of Medicare bad debt than other hospitals and reductions in these payments impact our hospitals to a greater degree than other hospitals. You have shown your understanding of the significant financial impact Medicare bad debt payments have on hospitals like ours by your willingness to increase the level of Medicare bad debt funding.

NAUCAH also supports the provision of your package, which freezes the BBA reductions in the Medicaid Disproportionate Share Hospital (Medicaid DSH) program for fiscal year 2001 and then correspondingly increases funding by the CPI. As you know, our hospitals provide a large amount of care to Medicaid recipients. Restoration of the Medicaid DSH limits will ensure that our state Medicaid agencies will not have to reduce our Medicaid revenues. However, our state Medicaid programs generally like to plan for longer terms than one year. It is difficult to predict how our state Medicaid agencies will react to short term changes in federal policy. This in turn makes it difficult for us to plan for the future, since we depend on these payments for a significant portion of our overall revenue. For this reason, while we are pleased with your provision for Medicaid DSH, we would have preferred a policy that would have lasted for a longer period to allow stability in our state Medicaid programs. Nonetheless, we cannot overstate our appreciation for a one-year freeze and we hope that we have convinced you that a long-term freeze of the Medicaid DSH reduction is important and will be seriously considered when this issue is discussed in the future.

In addition to Medicaid DSH, Medicare disproportionate share hospital payments (Medicare DSH) are an important part of the overall revenue of NAUCAH hospitals. Medicare DSH payments are made as part of the Medicare inpatient program and are intended to help ensure Medicare beneficiaries access to hospitals in their communities which might be impacted by the significant number of low-income patients they treat. NAUCAH supports your provision that freezes reductions to Medicare DSH and fully restores Medicare DSH in 2003.

We strongly believe that any revisions to the current Medicare DSH program that would increase the numbers of hospitals eligible for Medicare DSH payments or increase payments to some sets of hospitals, requires additional funding rather than reductions in payments to hospitals that presently receive Medicare DSH funds. NAUCAH hospitals are an integral part of the nation's safety net and cannot afford reductions in Medicare DSH payments if they are to continue to serve in this capacity. NAUCAH supports your language that provides additional Medicare DSH payments to rural and small urban hospitals without taking money away from large urban providers.

Once again, NAUCAH appreciates this opportunity for input. While we continue to ask that a provision to freeze the Medicaid DSH reductions for an additional year be added to the restoration package if an opportunity to do so becomes available this year, we are pleased that the concerns of the nation's private safety-net hospitals were seriously considered as this year's legislation was being crafted. The much-needed relief is sincerely appreciated. It is clear to us that you are concerned about the role that Medicare and Medicaid programs play in financing the safety-net for NAUCAH hospitals and that you considered our requests to be necessary and reasonable.

We look forward to working with you in the future on these issues so vital to the health care needs of America's low-income city residents.

Sincerely,

CHARLES L. DEBRUNNER,
Executive Director.

AMERICAN MEDICAL GROUP ASSOCIATION,
October 19, 2000.

Senator TRENT LOTT,
Senate Majority Leader,
Washington, DC.

DEAR SENATOR LOTT: As the 106th Congress enters its final session, the American Medical Group Association (AMGA) would like to take this opportunity to commend members of Congress for their hard work and diligence on a Medicare ''givebacks'' bill. The Beneficiary Improvement and Protection Act of 2000 (BIPA) is a positive step in restoring many of the unanticipated cuts suffered by Medicare providers as a result of the Balanced Budget Act of 1997 (BBA). AMGA has had an opportunity to view the bill in its entirety and would like to offer our full endorsement.

AMGA represents over 300 medical practice groups employing over 60,000 physicians in 41 states. Our members are the physician providers for over 30 million patients. AMGA members are among the largest and most prestigious medical groups in the country and include such renowned organizations as the Mayo Foundation, the Palo Alto Medical Foundation, the Lahey Clinic, the Henry Ford Health System, the Cleveland Clinic, and the Permanent Federation, Inc. AMGA's mission is to improve the health care environment by advancing accessible, high quality, cost-effective, patient-centered and physician-directed health care.

There are several aspects of the bill that we feel would greatly benefit our members. AMGA specifically supports the following provisions:

AMGA supports the elimination of the payment reductions for Indirect Medical Education (IME).

AMGA supports the clarification of physician certification.

AMGA supports a Medicare demonstration project for group practices.

AMGA supports provisions relating to the increased reimbursement for medicine services.

AMGA applauds the additional relief for rural hospitals. This is important to our members that provide access to basic health care services for Medicare and Medicaid beneficiaries.

AMGA believes that many of the managed care provisions will not only be beneficial to our members but will also afford better care to the patients we serve. AMGA specifically supports several provisions in the bill relating to managed care:

AMGA supports a $475 floor as well as the $525 urban floor for metropolitan statistical areas with populations of 250,000 people or more as current reimbursement amounts are inadequate.

AMGA supports the 10% phase-in of the risk adjuster, which will greatly benefit individuals with chronic conditions.

AMGA supports expansion of application of entry bonus payments in 2001 that will facilitate greater participation from all health care providers.

AMGA enthusiastically supports and applauds BIPA, and believes that it represents a significant step in the right direction of restoring equity to health care providers. Each of the provisions mentioned above will not only allow AMGA members to continue to participate in the Medicare program but also facilitate it. We encourage members of Congress to work together in a bipartisan manner to make sure this bill is passed and signed into law. We encourage Democrats and Republicans to come together to vote for this bill, as it will greatly enhance the availability of health care services to all Medicare beneficiaries. Lastly, we encourage the President to sign this bill and restore many of the unanticipated cuts.

Thank you for your consideration.

Sincerely,

DONALD W. FISHER, PH.D., CAE
President and Chief Executive Officer.

MISSISSIPPI HOSPITAL ASSOCIATION,
Jackson, MS, October 23, 2000.

Hon. TRENT LOTT,
U.S. Senate, Washington, DC.

DEAR SENATOR LOTT: On behalf of the Mississippi Hospital Association I want to express our appreciation for the exemplary work that you have done in regard to the House/Senate GOP package for Balanced Budget Act relief. The $28 billion five-year package, which includes $10 billion in assistance to hospitals, is a vital step in providing them relief from the unintended consequences of the '97 BBA.

I understand the tough position with which you are faced in attempting to balance the needs of numerous constituencies, the House of Representatives and the White House.

Thank you for your support of the hospital industry and the patients and families we serve.

Sincerely,

SAM W. CAMERON,
President and CEO.

October 19, 2000.

Hon. FRED THOMPSON,
U.S. Senate, Washington, DC.

DEAR SENATOR THOMPSON: On behalf of more than 150 hospitals and health systems in Tennessee, I would like to thank you and your staff for your continued support of meaningful relief from the Balanced Budget Act of 1997 (BBA). We sincerely appreciate your diligent efforts to provide ''give backs'' to providers for some of the unintended Medicare cuts that are quickly approaching two times the amount that Congress originally intended.

We applaud your committee's work as the first to endorse the notion of a two-year full inpatient market basket update—an idea that THA strongly supports. In the remainder of the draft compromise language, I am confident that you have also created some real relief in many of the provisions as included by your committee. Specifically, we continue to strongly support your:

increases in the inpatient, outpatient, SNF and home health market basket updates;

increases for Medicare bad debt reimbursement;

improvements in Medicare DSH both in terms of overall payments and qualifying

thresholds between urban and rural providers;

delay of the home health cuts another year—as well as other operational improvements;

increases to teaching hospitals via improvements in IME and GME payments;

other targeted fixes for rural, psychiatric, rehabilitation, and other providers.

While these provisions (along with the fixes from last year) are very helpful to providers, they still only partially address the problems with the BBA. Therefore, I urge you to eliminate the remaining two years of reductions in the hospital inpatient system and ask that no additional reductions be made in FY 2003 and beyond. Additionally, we ask that you fully restore Medicare bad debt payments and eliminate the 15% reduction in home care payments.

As you know, without these relief measures, the BBA will continue to have a devastating effect on the providers in your home state. Coupled with the increasing levels of uncompensated care from TennCare and charity care, these cuts cannot be sustained and will continue to erode the health care infrastructure in Tennessee.

Given the projections for the budget surplus in coming years, we are asking for nothing more than adequate reimbursements to providers to cover their costs of delivering care. As evidenced by your support thus far, you and the Senate Finance Committee fully understand the repercussions of a failure to provide anything short of significant, substantial BBA relief—and we thank you for that.

Again, senator, we truly appreciate your continued work on behalf of our providers and their patients and communities. I am hopeful that you and the Committee will continue to support these non-partisan efforts to restore provider payments and urge the Administration to do the same.

Sincerely.

CRAIG A. BECKER, FACHE
President.

THE UNIVERSITY OF TEXAS SYSTEM,
Austin, TX, October 19, 2000.

Chairman BILL ROTH,
Senate Finance Committee, U.S. Senate, Washington, DC.

DEAR CHAIRMAN ROTH: At your request we have reviewed the broad outlines of your legislation to provide much needed relief to health care providers, more specifically your provisions to help our Nation's teaching hospitals. We fully recognize the enormity of this task—seeking to provide assistance that is fair, balanced and appropriate among equally compelling claims from providers all across the health care system. Striking a balance among these competing needs while continuing to address the long-term solvency of the Medicare Trust Fund is the challenge. We appreciate your dedication to these goals and your willingness to consider that assistance to America's teaching hospitals is in the long-term interest of preserving our world preeminence in research and medical advancement.

In particular, we believe that provisions addressing Medicare's Direct (DGME) and indirect Graduate Medical Education (IME) programs, and those provisions addressing the Medicaid Disportionate Hospital Share (DSH) program, represent a good faith attempt on the part of Congress to correct the largely unforeseen inequities that arose from the Balanced Budget Act of 1997 (BBA). Each of our Nation's teaching hospitals and academic health centers confronts different financial constraints and pressures, the result of a constantly changing, evolving health system.

We congratulate you for your efforts and skill in writing a balanced legislative package that addresses many of our needs, and we commend your dedication to sound policies in support of academic medicine and the students and patients that we serve.

Sincerely,

CHARLES B. MULLINS, M.D.
Executive Vice Chancellor for Health Affairs.

NATIONAL ASSOCIATION
OF PSYCHIATRIC HEALTH SYSTEMS,
Washington, DC, October 19, 2000.

Hon. WILLIAM THOMAS,
Chairman, House Ways and Means Health Subcommittee, House of Representatives, Washington, DC.

DEAR CHAIRMAN THOMAS: On behalf of the National Association of Psychiatric Health Systems, I want to express our gratitude to you for including in the House-Senate Medicare relief package the provision that would provide a 1% bonus increase in TEFRA payments to psychiatric hospitals and units of general hospitals. We support passage of this bill in the House and oppose a presidential veto.

This financial relief is very much needed, as demonstrated in MedPAC's June 2000 Report to Congress. MedPAC data shows a post-1977 Balanced Budget Act (BBA) decline in Medicare margins (from 2.6%−2.3%) for psychiatric facilities—findings that are consistent with an earlier financial impact analysis of the effects of the BBA on psychiatric facilities prepared for NAPHS by Health Economics Research, Inc. Compounding these BBA payment reductions has been an 11-year decline in the value of employer-provided behavioral benefits, according to a 1999 study by the Hay Group.

For these reasons, we are grateful for your efforts needed financial relief to psychiatric hospitals and support House passage of the Medicare package with the 1% bonus increase for psychiatric facilities.

Sincerely,

MARK COVALL,
Executive Director.

HEALTH CARE LEADERSHIP COUNCIL,
Washington, DC, October 19, 2000.

Hon. WILLIAM M. THOMAS,
Chairman, Ways and Means Subcommittee on Health, Rayburn House Office Building, Washington, DC

DEAR CHAIRMAN THOMAS: The Healthcare Leadership Council (HLC) urges that Congress pass and the President sign Medicare refinement and benefits improvement legislation. This legislation will provide significant and much needed relief for Medicare providers and plans while also enhancing benefits and allowing quicker access to medical innovations for beneficiaries.

The HLC is comprised of chief executives of America's leading health care organizations, representing a cross section of the entire industry. Our members represent community and teaching hospitals, pharmaceutical companies, Medicare+Choice plans, medical technology companies and other organizations providing products and services to Medicare beneficiaries. They know firsthand the serious effects Medicare payment reductions have on the delivery of services to Medicare beneficiaries. While this package will not restore all of the reductions enacted in 1997, it will provide substantial immediate relief to help stabilize the Medicare program.

It is imperative that this legislation be enacted to assure that Medicare beneficiaries receive the highest quality care and coverage and so we can lay a solid foundation for achieving comprehensive Medicare reform in the near future.

We look forward to working with you to achieve enactment of this important legislation.

Sincerely,

MARY R. GREALY,
President.

NATIONAL ASSOCIATION FOR HOME CARE,
Washington, DC, October 19, 2000.

Hon. WILLIAM THOMAS,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: Many thanks for once again providing leadership to help blunt some of the unintended consequences of the Balanced Budget Act of 1997 (BBA). Your efforts, as always, are greatly appreciated.

Balancing concerns about fiscal responsibility with the interests of Medicare beneficiaries and the providers that serve them is a very difficult job. We are grateful that you have offered to delay the scheduled 15 percent cut for an additional year, to provide a full market-basket inflation update for fiscal year 2001, and to extend periodic interim payments for two months. These provisions will be of great help to home health agencies and the patients they serve. However, with all due respect, as the benefit most hard-hit by the BBA, home health providers and the patients they serve are in need of additional support in order to further stabilize the program and enhance access to needed care.

As you know, under the BBA, home health outlays dropped 54 percent in a two-year period and the total number of beneficiaries served dropped by nearly 1 million. The BBA has exacted $70 billion from the home health program, more than four times the $16 billion savings target set by the Congress. The number of home health agencies has dropped by about one-third, and the budgets of those agencies remaining have dropped by close to 40 percent.

We urge your further consideration of several proposals that are designed to help shore up the ailing home health program—specifically, requiring payment for non-routine medical supplies on a fee schedule rather than as part of the prospective payment base payments (this proposal would be budget-neutral); increasing allowable expenditures for high cost, outlier patients; and additional payments for care provided to rural patients. Senator William Roth has seen fit to include these provisions in a bipartisan legislative package he has proposed, and we would encourage you to work with your colleagues to address these areas as you finalize the BBA refinements package.

Your assistance in this regard will be greatly appreciated—not only by the home health agencies, doctors, nurses, and home health aides that provide these important services, but also by the millions of vulnerable Medicare beneficiaries that rely on us for their care and protection.

Many thanks for your thoughtful consideration of our requests.

Sincerely,

VAL J. HALAMANDARIS,
President.

AMERICAN ASSOCIATION FOR HOMECARE,
Alexandria, VA, October 19, 2000.

Hon. WILLIAM THOMAS,
Subcommittee on Health, Longworth House Office Building, Washington DC.

DEAR CHAIRMAN THOMAS: The American Association for Homecare representing over 3,000 home nursing and durable medical equipment providers supports enactment of the legislation crafted by the House and the Senate health policymakers.

Recognizing the current proposal refines the Balanced Budget Act of 1997 for the fiscal year 2001, the Association would like to

thank you for your efforts to support homecare. The following provisions will help homecare providers within the next year by:

Restoring the durable medical equipment providers CPI for fiscal year 2001;

Delaying any reduction of payment by HCFA of the average wholesale pricing for drugs to ensure patient access to quality equipment and supplies with a study by the General Accounting Office;

Restoring the home health market basket update for fiscal year 2001;

Extending the home health periodic interim payments for two months;

Clarifying the definition of homebound to permit home health services to be furnished to patients in adult day care settings;

Delaying the 15% cut for home health services for one-year; and,

Requesting a study to review the consolidated billing requirements under PPS.

As you know, the homecare industry has undergone significant reductions that have resulted in the lack of patient access to needed medical services and supplies. The latest figures show a reduction of more than 50% from 1997 to 1999 with over one million eligible Medicare beneficiaries who are no longer receiving homecare services. The Association continues to strongly advocate for complete elimination of the additional 15% cut to home health services. This provision has both wide-spread, bi-partisan Congressional as well as consumer support, and we look forward to working with you on a Medicare proposal in the future that will help to address this issue.

The Association would appreciate your consideration of the following technical changes to the legislative proposal:

Require the Medicare Payment Advisory Commission (MedPAC) to study the necessity of the 15% cut for home health services rather than the General Accounting Office; and,

Expedite the requirement by the General Accounting Office to study the consolidated billing provisions under the home health PPS and impose a delay of the requirement until such study is completed. If this is not feasible, require HCFA to suspend medical review on both DME and home health providers until clear guidance by HCFA and its Medicare contractors has been issued to providers.

Thank you for your consideration on these two technical changes. Once again, the American Association for Homecare greatly appreciates your efforts to help homecare providers, and we look forward to working with you next year on these important issues.

Sincerely,

THOMAS A. CONNAUGHTON,
President and CEO.

AMERICAN FEDERATION OF HOMECARE PROVIDERS, INC.,
Silver Spring, MD, October 19, 2000.

Congressman WILLIAM THOMAS,
Chairman, House Ways and Means Health Subcommittee, House of Representatives, Washington, DC.

DEAR CONGRESSMAN THOMAS: The American Federation of HomeCare Providers appreciates your addressing several issues of critical importance to Medicare participating home health agencies in your Medicare refinement legislation. Our members are primarily freestanding providers, the majority of which have been severely affected by the Balanced Budget Act of 1997.

We are pleased that you have included a provision to postpone for another year, to October 1, 2002, the additional 15 percent reimbursement reduction, and that you have provided for an update of 2.2 percent of the HHRG rates for the second half of Fiscal Year 2001, adding back $1.3 billion in finding over a five-year period. Extension of PIP for two months will assist providers who might otherwise be financially destabilized by the unadjusted rates and payment disruptions in the initial phase of home health PPS. In addition, you have indicated your desire to address the issues of non-routine medical supplies, the definition of ''homebound'' and branch office policy, commissioning GAO studies in all three cases, and clarified the role of telemedicine in the home care setting. We are appreciative.

It is critical to the survival of home health providers, however, that the 15 percent reduction be permanently eliminated. Additionally, it is imperative that the issue of access to home care services for medically complex and high cost patients be addressed, perhaps as envisioned in Congressman John Peterson's legislation. While your bill addresses issues related to the new prospective payment system, we have outstanding concerns about patients who lost their access through the strictures of the Interim Payment System, which cut $79 billion from the benefit. And for the sake of the effective administration of the home care benefit, consolidated billing of non-routine medical supplies should be addressed forthwith, by simply eliminating the requirement and reimbursing on a fee schedule basis.

We urge you to continue to work with other Members of Congress and the Administration in the next few days to address these pressing concerns, which as they related to access for complex and high cost patients can be a matter of life and death. We want to work with you and your colleagues the rest of this session, and early in the next Congress, for restoration of beneficiary access lost under IPS, permanent elimination of the 15 percent cut, and a more rational medical supply policy under PPS.

Again, thank you for your attention to our concerns.

Sincerely yours,

ANN B. HOWARD,
Vice President for Policy.

THE ALLIANCE FOR QUALITY NURSING HOME CARE,
October 19, 2000.

Hon. BILL ROTH,
Chairman, Senate Committee on Finance, Washington, DC.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means, Washington, DC.

Hon. TOM BLILEY,
Chairman, Committee on Commerce, Washington, DC.

DEAR CHAIRMAN ROTH, CHAIRMAN ARCHER AND CHAIRMAN BLILEY: On behalf of the Alliance for Quality Nursing Home Care, I want to express our gratitude for your leadership in recognizing the crisis that exists today in the delivery of skilled nursing care to Medicare beneficiaries. The efforts Congress have undertaken this year to refine Medicare reimbursement levels will ensure that seniors continue to have access to quality nursing home care. The Alliance for Quality Nursing Home Care supports the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, and we urge Congress to overwhelmingly support its passage during the remaining days of the 106th Congress.

Your attention to increasing the nursing component for the prospective payment system will help nursing homes working to address some of the most critical issues facing our profession: Retaining, recruiting and training quality nursing home staff. In addition, we look forward to continuing to work with Congress and the Administration on addressing the fundamental payment shortcomings of the current market basket inflation index that understates the cost of caring for medically complex patients.

Sincerely,

MICHAEL WALKER.

AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING
Washington, DC, October 19, 2000.

Hon. DENNIS HASTERT,
Speaker, U.S. House of Representatives, Office of the Speaker, Washington, DC.

DEAR MR. SPEAKER: As members of the Interfaith Coalition representing faith based and other non-profit providers of long term care services, we are writing to express our concern on a provision contained within the Medicare ''Giveback'' legislation of great importance to seniors. The Balanced Budget Act Refinement bill approval by the Ways and Means Health Subcommittee included language to provide seniors in managed care health plans the option of returning to their nursing home or long-term care facilities to receive care after hospitalization. This portion of the bill, which was championed by Representatives Pryce and Hobson, will allow seniors control over their own health care needs.

When elderly nursing home or retirement community residents who belong to managed care plans are hospitalized, upon discharge they are often not allowed to return to their home facilities for further care if those facilities are not part of the managed care plan's network. We should not allow our elderly and frequently frail nursing home residents to be forced to uproot themselves and possibly endanger their health following a severe health crisis. The ''Return to Home'' provisions require Medicare+Choice plans to cover the care provided in the long-term care facility where the residents lived prior to hospitalization.

It is our understanding that this important provision will be included in the final version of the bill. These provisions will help improve the health and well-being of seniors by enabling them to return to the skilled nursing facility where they have strong personal and in many cases family ties. On behalf of our organizations which respectively represent over tens of thousands of members, encourage you to help all seniors by protecting the ''Return to Home'' provisions and passing Medicare legislation before the end of the 106th Congress.

We offer our appreciation for your efforts to this extremely important matter.

Sincerely,

American Association of Homes and Services for the Aging Volunteers of America.

VNAA,
VISITING NURSE ASSOCIATIONS OF AMERICA,
October 20, 2000.

Hon. WILLIAM M. THOMAS,
Chairman, Health Subcommittee, House Ways and Means Committee, Washington, DC.

DEAR CHAIRMAN THOMAS: On behalf of the Visiting Nurse Associations of America (VNAA), I would like to thank you for developing legislation to further relieve the unintended adverse effects that the Balanced Budget Act of 1997 (BBA) has had on Visiting Nurse Agencies (VNAs) and other home health care providers.

VNAA supports the ''Medicare, Medicaid and SCHIP Beneficiary Protection and Improvement Act of 2000'' because of its provisions to: Delay the 15% cut until fiscal year (FY) 2003; Provide an extension of Periodic Interim Payments (PIP) to PIP providers through November 30, 2000; and Increase the Medicare home health prospective payment base rate by 2.2% for the second six months of FY 2001.

VNAA believes a study of the costs of non-routine medical supplies and the appropriateness of bundling such supplies into

PPS rates is greatly needed. We are pleased that your legislation accomplishes this goal. VNAA encourages you to expedite this study because of our strong concerns about the cost of supplies used in the treatment of wounds, incontinence, and outpatient therapy.

We also are concerned about our operational ramifications involving health medical equipment (HME) suppliers and home health providers. Currently, there are not electronic measures to determine if patients at admission are receiving supplies from either a HME supplier or a home health provider. Patients who have chronic conditions and have been receiving medical supplies for years are often not clear about the origin of their supplies. Did they originate with the physician?, the hospital?, the HME supplier?, the nurse? Therefore, innocent provisions of such supplies by both the HME suppliers and the home health agency to the same patient could easily subject providers to medical review and allegations of fraud and abuse. VNAA urges you to suspend medical review of medical supplies until such electronic or other means is operational.

VNAA was very pleased to meet with you, to testify before your subcommittee, and to work with your staff, Linda Fishman and John McManus this year. As you know, repeal of the 15% cut is critical to VNA's survival. We greatly appreciate your assurance to us that cost-effective and ethical home health providers will never be subject to the 15% cut. We ask for your support to achieve full elimination of the 15% cut next year. Full repeal of this provision would ease the concerns of financial lenders, thereby improving cash flow for VNAs during difficult financial times. In addition, please require the Medicare Payment Advisory Commission (MedPAC), rather than the U.S. General Accounting Office (GAO), to conduct the study regarding the 15% cut. We do not believe that the GAO has conducted thorough and fair studies regarding Medicare home health issues.

Finally, we cannot thank you enough for your support of VNAA's recommendation to extend PIP to ease cash flow during the transition to PPS. This provision in your legislation will literally prevent the closure of several VNAs.

VNAA looks forward to continuing to work with you next year and in the future.

Sincerely,

CAROLYN S. MARKEY,
President and CEO.

NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION,
October 19, 2000.

Hon. WILLIAM V. ROTH, JR.,
Chairman, Finance Committee, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: We write to express our support for passage of the Medicare, Medicaid and SCHIP Improvement Act of 2000 which further refines the Balanced Budget Act of 1997. Medicare reimbursement of hospice care has not kept pace with the increasing costs of care for terminally ill Medicare beneficiaries as they approach death. Therefore, we support the hospice provisions included in your legislation; specifically, restoration of the full market basket increase (MBI) in the current fiscal year (FY 2001), maintenance of the fiscal year 2002 update as provided in the Balanced Budget Refinement Act (MB minus 0.25%), and full MB in FY 2003.

We appreciate the interest by many senators to improve the Medicare hospice benefit. Indeed, it is our hope that by clarifying the physician certification language in the statute to clearly rely on a physician's clinical judgment regarding the expected course of illness, physicians will feel more confident in referring terminally ill Medicare beneficiaries to hospice care. We are pleased that you include this provision in your legislation.

The National Hospice and Palliative Care Organization (NHPCO) has worked diligently to provide cost data to justify the need for a rate increase. Earlier this year, Milliman and Robertson provided interim data based on a large sample of 10,000 Medicare hospice patients. The cost data demonstrate significant increases in the cost to hospice providers of prescription drugs (1500+%) and outpatient services (500%) that was not envisioned when the original Medicare rates were established nearly twenty years ago. Coupled with these increased costs is a dramatic decrease in the length of hospice service. Recently, the General Accounting Office found that 28% of Medicare beneficiaries stayed in hospice for one week or less. As a point of comparison, the length of service was 70 days at the time the hospice rate was established. Since hospice providers are paid on a per diem and subject to an overall payment cap, significantly shorter stays eliminate providers' ability to absorb the higher cost days, especially when a patient is first admitted to hospice and again in the period immediately preceding death. Hospice has experienced consistent updates below the market basket increase. Over the years, the statutory reductions have amounted to more than 9.25%. Therefore, restoration of the reductions prescribed in BBA will assist hospice providers in meeting the complex care needs of those Medicare beneficiaries who choose to die at home under the care of hospice providers.

Finally, we look forward to continuing to work with you to strengthen the Medicare hospice benefit. Hospice is an expanded and all inclusive benefit package, including outpatient prescription drugs, palliative chemotherapy and radiation, and bereavement support for family members. It can be viewed as a substitute benefit providing terminally ill Medicare beneficiaries with a choice other than the traditional fee-for-service program. It is our hope that we can work together in the future to assure that Medicare reimbursement adequately reflects the true cost of caring for terminally ill Medicare beneficiaries, maintains a high quality of care, and protects this important choice for those who wish to die with dignity in the setting of their choice, surrounded by family.

Sincerely,

KAREN A. DAVIE,
President.

NATIONAL PACE ASSOCIATION,
San Francisco, CA, October 19, 2000.

Hon. BILL THOMAS,
Chairman, Health Subcommittee, House Ways and Means Committee, Longworth House Office Building, Washington, DC.

DEAR CONGRESSMAN THOMAS: On behalf of the National PACE Association (NPA) and its members, I am writing to express the Association's appreciation for your continued support of the Programs of All-inclusive Care for the Elderly (PACE) through inclusion of provisions for PACE in The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000. The Act's provisions to expand the opportunities for flexibility in implementation of PACE programs and to ease the transition of existing demonstration sites to permanent provides status will have an immediate and ongoing positive impact on PACE programs and the frail elderly adults they serve.

Although we have not had an opportunity to study the legislative package in its entirety, your efforts on behalf of Medicare and Medicaid beneficiaries to strengthen those programs should be acknowledged and receive careful consideration from members of Congress and, if enacted, from the President as well as the bill makes its way through the final days of this legislative session.

Sincerely yours,

JUDITH BASKINS,
President.

ASSOCIATION OF OHIO PHILANTHROPIC HOMES, HOUSING AND SERVICES FOR THE AGING,
Columbus, OH, October 19, 2000.

Hon. DENNIS HASTERT,
Speaker of the House, The Capitol, Washington, DC.

DEAR REPRESENTATIVE HASTERT: I am writing to express my support (and the support of 185 not-for-profit nursing homes and retirement communities serving over 22,000 frail Ohioans) on a provision contained within the Medicare ''Giveback'' legislation. This provision is of great importance to seniors everywhere including those states which have had similar laws (hence the need for federal legislation) declared ''null and void'' by the Health Care Financing Agency—states such as California, Florida, Illinois, and Maryland.

The Balanced Budget Act Refinement bill approved by the Ways and Means Health Subcommittee, included language to provide seniors in managed care health plans the option of returning to their nursing home or long-term care facility to receive care after hospitalization. This portion of the bill, previously introduced by Representatives Pryce and Hobson as the ''Seniors Healing at Home Act,'' will allow seniors control over their own health care and healing.

When elderly consumers who belong to managed care plans are hospitalized and then discharged, they are often not allowed to return to where they had been living for further care if those facilities are not part of the managed care plan's network. The ''Seniors Healing at Home'' provision requires Medicare+Choice plans to cover the care provided in a senior's place of residence. It is my understanding that this important provision will be included in the final version of the bill.

The ''giveback'' legislation will help to bring stability to the Medicare program by ensuring proper payments to those who help to heal our nation's seniors. One of the most frequent reasons voiced by residents of our facilities for not joining a Medicare HMO is the fear that they will not be permitted to return to their community following hospitalization.

On behalf of my organization and its 330 not-for-profit members, I encourage you to help seniors by protecting the ''Seniors Healing at Home'' provision, and passing the legislation before the end of the 106th Congress.

Very Truly Yours,

CLARK R. LAW,
President/CEO.

October 19, 2000.

Hon. DENNIS HASTERT,
U.S. Congress, Washington, DC.

DEAR SPEAKER HASTERT: As faith-based organizations concerned about the health and welfare of elderly Americans, we strongly support your efforts to include Representatives David Hobson's (R–OH) and Deborah Pryce's (R–OH) Seniors Healing at Home Act (H.R. 5042) in the Balanced Budget Refinement Act under current consideration by Congress. We understand that this provision, an important step in ensuring that senior citizens are able to receive compatible skilled nursing care in their home communities, will be included in the final version of the BBRA.

The increasing prevalence of managed care among elderly individuals has had both positive and negative effects. Managed care can

lead to increased coordination of care and decreased costs, but it can also limit access to facilities that are close to home or culturally appropriate. An increasing number of older individuals are choosing to live in senior housing or assisted living complexes on campus settings with facilities that offer varying levels of care including convalescent and skilled nursing care. These individuals choose to live in this type of setting so that they can spend the remainder of their lives close to family and friends, frequently in an environment that facilitates religious observance.

A recent trend of great concern is that many indvidiuals in such communities are, upon discharge from a hospital, unable to return to the community where they had been living if that community's skilled nursing facility is not part of the Medicare+Choice plan's network of providers. The managed care plan may instead require that the consumer be discharged to a long term care facility in the plan's network, even though the facility may be distant from friends, family and spouse.

We believe that denying seniors the ability to return to their community of origin negatively impacts on quality of care. Access to close friends and loved ones may help prevent the isolation, depression and even trauma that can increase a frail individual's physical recovery time and the cost of care. The patient's medical care may suffer as well, since the staff of the facility where the individual had been living may be more familiar with the person's chronic care needs.

''Return to Home'' legislation would ensure that seniors living in a facility on a campus that provides skilled nursing care will be able to return to that facility for convalescent care. On behalf of our organizations and our members, we urge and applaud your continued support for the Seniors Healing at Home Act, and encourage you to pass this legislation before the end of the 106th Congress.

Sincerely,

Adventist Health Systems, Donald L. Jernigan, Executive Vice President.

American Jewish Committee, Richard T. Foltin, Legislative Director and Counsel.

American Protestant Health Alliance, Sherry Hayes, President.

Association of Brethren Caregivers, Steve Mason, Executive Director.

Association of Jewish Aging Services, Jodi Lyons, President.

Baptist Senior Adult Ministries, Edythe J. Walters, Executive Director.

Catholic Health, Association of the U.S. Julie Trocchio, Director of Long Term Care.

Church Women United, Tiffany L. Heath, Legislative Assistant.

Florida Council of Churches, Rev. Fred Morris, Executive Director.

Friends Committee on National Legislation, Florence Kimball, Legislative Education Secretary.

Jewish Council for Public Affairs, Reva Price, Washington Representative.

Lutheran Office for Governmental Affairs, Evangelical Lutheran Church in America, Rev. Russell O. Siler, Director, Washington Office.

Lutheran Services in America, Joanne Negstad, President/CEO.

National Council of Catholic Women, Annette Kane, Executive Director.

National Council of Jewish Women, Sammie Moshenberg, Director, Washington Office.

National Interfaith Coalition on Aging, Rev. Dr. Richard H. Gentzler, Jr., Chair.

Pennsylvania Council of Churches, Rev. K. Joy Kaufmann, Acting Executive Director and Director for Public Advocacy.

Union of American Hebrew Congregations, Mark J. Pelavin, Esq. Associate Director, Religious Action Center of Reform Judaism.

Union of Orthodox Jewish, Congregations of America, Nathan J. Diament, Director, Institute for Public Affairs.

Unitarian Universalist Association of Congregations, Rev. Meg Riley, Director, Washington Office for Faith in Action.

United Church of Christ, Office for Church in Society, Rev. Patrick Conover, Policy Advocate.

United Jewish Communities, Diana Aviv, Vice President for Public Policy.

The United Methodist Church, General Board of Discipleship, Rev. Dr. Richard H. Gentzler, Jr., Director, Office of Adult Ministries.

Volunteers of America, Ronald H. Field, Vice President of Public Policy.

PATIENT ACCESS TO TRANSPLANTATION COALITION,
Washington, DC, October 20, 2000.

Hon. WILLIAM V. ROTH, JR.,
Senate Finance Committee, Senate Dirksen Office Building, U.S. Senate, Washington, DC.

DEAR CHAIRMAN ROTH: The Patient Access to Transplantation Coalition would like to express our support for Section 113 of the Medicare, Medicaid and SCHIP Beneficiary Protection and Improvement Act of 2000. We are pleased that this provision of the final conference agreement will eliminate the current three-year limitation on coverage for immunosuppresive drugs under the Medicare program. We would especially like to thank you, Senator DeWine, and Chairmen Bliley, Thomas and Bilirakis for your tremendous leadership on this important transplant patient issue.

This provision is urgently needed to ensure that Medicaid beneficiaries who receive organ transplants can continue to have access to these lifesaving drugs. We are confident that the Medicare program will ultimately save money as a result of this provision, since it will reduce the number of organ failures which necessitate subsequent retransplantation. We also believe that, by reducing the number of organ rejections, this provision will result in the availability of an increased number of organs for the almost 70,000 patients who are currently waiting to receive the gift of life.

Once again, we appreciate and commend your efforts to expand Medicare coverage of immunosuppressive drugs this year. Your efforts will help ensure that transplant patients across the country continue to have access to lifesaving immunosuppressive therapies.

Sincerely yours,

PATIENT ACCESS TO TRANSPLANTATION COALITION.

October 19, 2000.

PAT COALITION INSTITUTIONAL MEMBERS

Clarian Health Partners (Indianapolis, IN).

Emory University (Atlanta, GA).

Froedert Memorial Lutheran Hospital (Milwaukee, WI).

Henry Ford Health System (Detroit, MI).

Inova Health System (Fairfax, VA).

Jewish Hospital (Louisville, KY).

Louisiana State University (Shreveport, LA).

Medical University of South Carolina (Charleston, SC).

Memorial Hermann Healthcare System (Houston, TX).

Memorial Medical Center (New Orleans, LA).

Ochsner Medical Institutions (New Orleans, LA).

Ohio State University Medical Center (Columbus, OH).

Oklahoma Transplantation Institute (Oklahoma City, OK).

Oregon Health Sciences University (Portland, OR).

St. Louis University Hospital (St. Louis, MO).

St. Vincent Medical Center, CHW (Los Angeles, CA).

Scripps Clinic (La Jolla, CA).

Tampa General (Tampa, FL).

Tulane University (New Orleans, LA).

University of Alabama at Birmingham (Birmingham, AL).

University of Colorado Health Sciences Center (Boulder, CO).

University of Florida/Shands Hospital (Gainesville, FL).

University of Kansas (Lawrence, KS).

University of Kentucky (Lexington, KY).

University of Medicine and Dentistry of New Jersey (Newark, NJ).

University of Michigan (Ann Arbor, MI).

University of Washington (Seattle, WA).

University of Wisconsin-Madison (Madison, WI).

Vanderbilt University Medical Center (Nashville, TN).

Virginia Commonwealth University Medical College of Virginia (Richmond, VA).

Westchester Medical Center (Valhalla, NY).

LIFECARE MANAGEMENT SERVICES,
Dallas, TX, October 19, 2000.

Re: Provider Based Determinations

Hon. DENNIS HASTERT,
Speaker of the House, House of Representatives, Washington, DC.

DEAR REP. HASTERT: I would like to thank you for your time and assistance in supporting legislation designed to treat long-term care hospitals equitably in terms of payment and program administration.

We are particularly grateful for your support for the provision that would provide a two year delay in the application of HCFA's new provider-based determination rule (See Section 404 enclosed).

We gratefully appreciate your leadership and know you will do everything you can to make certain the enclosed provision is adopted as part of this year's BBA Relief Package.

Sincerely,

DAVID LABLANC,
President.

AMERICAN CANCER SOCIETY, NATIONAL GOVERNMENT RELATIONS OFFICE,
October 19, 2000.

Hon. J. DENNIS HASTERT,
Speaker of the House of Representatives, U.S. Capitol Building, Washington, DC.

DEAR MR. SPEAKER: On behalf of the more than 18 million volunteers and supporters of the American Cancer Society, I am writing to thank you for supporting an extension of Medicare's current colonoscopy benefit to average risk beneficiaries in the Balanced Budget Refinement Act (BBRA) currently being negotiated. Securing this change has been one of the Society's top legislative priorities, as it will have a direct impact on reducing the incidence and mortality rates of colorectal cancer among the Medicare population.

As you know, this provision has broad bipartisan support and was included in all the bills considered by the House Ways and Means Health Subcommittee, the House Commerce Committee, and the Senate Finance Committee. President Clinton has also called for expansion of the current Medicare colon cancer screening benefit before the adjournment of this session of Congress. The bipartisan provision currently in the BBRA bill would bring Medicare coverage more in line with the American Cancer Society's current colorectal cancer screening guidelines. Colorectal cancer—the nation's second leading cause of cancer deaths in men and

women—most often is diagnosed in individuals considered to be ''average risk'' for the disease with approximately 70–90 percent of colorectal cancers diagnosed in average or moderate risk individuals. As daunting as these statistics are, colorectal cancer is second only to lung cancer in our ability to prevent cancer from ever occurring. This disease is easily preventable through the early identification and removal of pre-cancerous polyps, detectable only through colorectal cancer screenings.

Recent studies published in the New England Journal of Medicine found that colonoscopy is the most effective screening tool currently available. We know that if we were able to get all individuals screened for colorectal cancer—according to our guidelines—that we *could reduce overall colorectal cancer mortality by 50 percent or more.*

Increasing the numbers of Medicare beneficiaries that have access to the full range of effective colorectal cancer screening tests could save money on the cost of treatment. Colonoscopy can examine the entire colon and it is the most effective test at catching cancers at early stages. Colonoscopy also permits the health care provider to identify and remove adenomatous polyps—a procedure that can prevent colorectal cancer from ever developing. Other screening tests are not only less effective at detecting polyps and cancer but if polyps or signs of cancer are identified (e.g. occult blood) the patient then requires a colonoscopy. By providing average-risk patients the option of a screening colonoscopy, a second follow-up procedure in many cases can be avoided which not only saves Medicare money, but also saves the patient from additional hassle and discomfort.

We know that cancer is most effective when the cancer is caught early. For example, when cancer is diagnosed in the earliest stages—before it has become symptomatic—patients have a 90 percent chance of survival. Yet, if a patient is not diagnosed until symptoms are exhibited, the chance of survival drops to 8 percent and care during the remaining 4–5 years of life can cost up to $100,000. The Medicare reimbursement rate for colonoscopies is currently $337. While that may seem high, the Society's guidelines specify that a colonoscopy need only be performed once every ten years in individuals who have had a previous normal exam.

The Society strongly recommends that public and private health plans provide coverage for the full range of effective colorectal and other cancer screening tests according to the Society's guidelines. The current Medicare benefit provides coverage for: An annual fecal occult blood test (FOBT) for all beneficiaries over 50, A flexible sigmoidoscopy every 4 years for average or moderate risk beneficiaries*, A colonoscopy every 2 years for high risk beneficiaries*.

*A double contrast barium enema may be used as an alternative if a physician determines that its screening value is equal to or better than a flex-sigmoidoscopy or a colonoscopy.

The language in the BBRA bill provides average risk beneficiaries with coverage for either a colonoscopy every 10 years or a flexible sigmoidoscopy every four years. We applaud your action in embracing this change as it will provide the greatest flexibility for patients and their physicians in determining which screening modality is best for the individual beneficiary, while considering other factors such as costs and possible complications. This correctly places the screening decision with patients and providers and ensures that lack of coverage will not be a reason for a beneficiary to go without a potentially life-saving test.

The American Cancer Society thanks you for your support of this important public health matter and is hopeful that this change in policy will be enacted before Congress adjourns. While the Society is not in a position to comment on the merits of the full BBRA bill—both because we have not had an opportunity to analyze the specifics of this large package and because we understand that the package contains provisions that are beyond the scope of current ACS policy and legislative priorities—we urge all parties to continue to work toward ensuring enactment of the expanded colorectal cancer screening benefit. Therefore, we strongly urge Members of Congress and the Administration not to allow end-of-session politics to jeopardize this critical opportunity to save lives.

We look forward to working with you and your colleagues to ensure that this provision becomes law, Should you have any questions or if you would like additional information, please contact Wendy Selig, Managing Director of Federal Government Relations (202/661–5704), or Ilisa Halpern, Director of Federal Government Relations (202/661–5717).

Sincerely,

DANIEL E. SMITH,
National Vice President, Federal and State Government Relations.

ALLIANCE TO SAVE CANCER CARE ACCESS,
AMERICANS UNITED IN SUPPORT OF CANCER CARE,
Washington, DC, October 19, 2000.

Hon. [LOTT/DASCHLE/HASTERT/GEPHARDT]

DEAR SIR: We would like to express our appreciation for your focus on problems impacting the Medicare program, as well as our strong support for legislative reform that rationalizes Medicare reimbursement and preserves patient access to care.

As you know, many throughout the cancer community have long contended that the Medicare program employs a flawed reimbursement structure, overpaying for many drugs while underpaying for many services. For example, the Medicare program does not adequately support the critical role played by oncology nurses, forcing caregivers to engage in a form of ''cost shifting'' in which they have to use drug overpayments to offset Medicare's deep underpayment for the treatment services provided to beneficiaries. At the same time, the Health Care Financing Administration has acted upon a proposal to restrict Medicare coverage of injectable therapies that are needed by and have been historically provided to seniors and disabled Americans suffering from cancer, multiple sclerosis, AIDS, and other diseases.

These problems are widely considered to be unacceptable for several reasons: They are they source of great uncertainty for seniors and people with disabilities, they place significant pressures on the professional caregivers who care for them, and they are made necessary by correctable flaws in the Medicare statute.

Fortunately, legislation developed by Congress addresses these problems in a responsible and commendable manner. Provisions included in the Medicare reform package direct the Secretary to revise the payment methodology for all drugs currently covered by Medicare and charges the General Accounting Office to undertake the meaningful analysis which will support this much-needed correction. Meanwhile, another provision in the legislative package clarifies coverage of drugs that are usually not self-administrable and strengthens access to this important form of care. This combined response puts Medicare on the road to real, balanced, and sustainable reform by ensuring that the program provide appropriate reimbursement for drugs and will eliminate underpayments for services related to the provision of those therapies.

For these reasons, we are pleased to extend our congratulations to you and your colleagues for the fine work you have done to address these vital issues. We are pleased to extend to you our support for these provisions and hope that they will not be subject to any changes. Rather, we respectfully urge Members to strengthen patient access to cancer care by supporting the measure in which these provisions are brought before the Congress. We also express our appreciation to the president for his leadership in cancer care issues and our hope that he sign these important reforms into law.

On behalf of the seniors and disabled Americans we are honored to serve and represent, we would like to thank you for your consideration and your support.

Sincerely,

AMERICAN COLLEGE OF RADIATION ONCOLOGY
ASSOCIATION OF COMMUNITY CANCER CENTERS NATIONAL PATIENT ADVOCATE FOUNDATION.
ONCOLOGY NURSING SOCIETY UNITED SENIORS ASSOCIATION US ONCOLOGY.

ICC,
INTERCULTURAL CANCER COUNCIL,
October 19, 2000.

Hon. WILLIAM V. ROTH, JR.,
Chairman, Committee on Finance, Washington, DC.

DEAR SENATOR ROTH: On behalf of the Intercultural Cancer Council (''ICC''), including our 55 members and hundreds of affiliated organizations and supports, I write in support of the minority cancer demonstration provisions included in the Balanced Budget Act Relief Legislation. The ICC is the largest nationwide cancer coalition addressing the tragic disparities in cancer incidence and mortality rates in our nation's ethnic minority and medically underserved populations. The ICC's members work daily in the areas of cancer prevention and control, research, treatment and survivorship.

The Intercultural Cancer Council commends your leadership for including Rep. John Lewis' amendment in the final ''Medicare, Medicaid, SCHIP Beneficiary Protection and Improvement Act of 2000''. This timely demonstration effort should facilitate development of needed models and evaluations of methods to improve the quality of items and services provided to targeted individuals in order to reduce disparities in early detection and treatment of cancer among Medicare beneficiaries. We urge Congress to direct the Health Care Financing Administration to proceed expeditiously to implement this provision and ensure that these demonstrations are launched in a timely manner.

As the ICC's mission includes identifying problems in access to cancer detection and treatment, developing collaborative solutions, and promoting new partnerships to implement those solutions, we endorse the direction of the proposed demonstration language. We believe special attention should be given in demonstration projects to mechanisms designed by and for the ethnic minority and medically underserved communities that suffer the grossly disproportionate burden of cancer in this country.

Again, we appreciate your recognition of the need to address disparities in access and cancer treatment for ethnic and racial minorities who are Medicare-eligible. Enactment of this provision represents a first step in moving forward to address a significant health disparity problem facing this nation

and we are grateful for your leadership in this area.

Sincerely,

ARMIN D. WEINBERG.

THE SUSAN G. KOMEN BREAST CANCER FOUNDATION,
NATIONAL HEADQUARTERS,
Dallas, TX, October 6, 2000.

Hon. WILLIAM ROTH,
Chairman, Committee on Finance, U.S. Senate, Washington, DC.

DEAR CHAIRMAN ROTH: On behalf of the Susan G. Komen Breast Cancer Foundation, I am writing to urge you to include funding for digital mammography in the Medicare initiative currently being shaped by Congress.

The Medicare, Medicaid and SCHIP Improvements Act of 2000 provides a valuable opportunity to recognize and promote a new technology that offers many exciting possibilities. The Komen Foundation urges its inclusion in the interest of advancing women's health. Digital mammography creates high definition pictures for detection and diagnosis of breast cancer in its earliest, most curable stages. Doctors can easily transmit images from remote areas to specialists worldwide for expert consultation. Digital mammography also requires fewer tests and yields faster results, which translates into lower exposure to radiation and greater convenience for Medicare beneficiaries.

The Komen Foundation recognizes the limitations of current mammography and has dedicated its own research funding towards the pursuit of new screening and diagnostic technologies, including digital mammography. Now that this cutting-edge technology has received FDA approval and shown promise in the early detection of breast cancer, it is important to distribute it widely and enable women all over the country to receive its benefits. In the closing days of Congress, Komen asks you to please help promote this new scientific advancement for women's health. The estimated cost is only $87 million over five years.

The mission of the Susan G. Komen Breast Cancer Foundation is to eradicate breast cancer as a life-threatening disease by advancing research, education, screening, and treatment. To this end, the Komen Foundation dedicates millions of dollars annually towards scientific research, education and community outreach. But we cannot do it alone. The eradication of breast cancer as a life-threatening disease requires the support of dedicated Members of Congress like you. Your continued efforts in the battle against breast cancer are deeply appreciated.

Thank you very much.

Sincerely,

NANCY BRINKER,
Founding Chairman.

NATIONAL KIDNEY FOUNDATION,
OFFICE OF SCIENTIFIC AND PUBLIC POLICY,
October 19, 2000.

Hon. WILLIAM M. THOMAS,
Committee on Ways and Means, Washington, DC.

DEAR REPRESENTATIVE THOMAS: The National Kidney Foundation (NKF) supports the package of Medicare improvements under consideration in Congress, particularly the provisions described below. NKF is the country's oldest and largest voluntary health agency serving the needs of kidney patients with over 30,000 members from every part of the nation and from every walk of life, including consumers and their families, nurses, dietitians, social workers, physicians, dialysis technicians and concerned members of the lay public.

The National Kidney Foundation urges Members of Congress to vote for the package and exhorts the President to sign the legislation. We especially endorse the following provisions and thank you for including them in the bill.

Two provisions in the Beneficiary Improvement section would be of enormous benefit to kidney patients. They result from recommendations made by the Institute of Medicine of the National Academy of Sciences last December as part of studies mandated by Congress in the Balanced Budget Act of 1997. Section 113 removes the existing time limitation on Medicare coverage for immunosuppressive medications needed by transplant recipients. Without this enhanced benefit, tens of thousands of transplant recipients run an increased risk of rejecting their transplants. Rejection could result in a return to dialysis, which Medicare covers and which costs the government much more than the drugs which preserve the functioning of a transplant. Section 105 authorizes Medicare payments for nutritional counseling for pre-dialysis and post-transplant patients. This could benefit 80,000 Americans who are faced each year with the prospect of irreversible kidney failure and the changes in diet which are required to prepare these patients for that eventuality, as well as 12,000 kidney transplant candidates who receive the Gift of Life annually and thus need to adjust their dietary intake when they become transplant recipients. Nutritional counseling has been shown to reduce morbidity and mortality in these populations.

Section 422 under Part B Improvements provides for an update in the reimbursement rate paid for kidney dialysis treatments as recommended by the Medicare Payment Advisory Commission. NKF has pioneered in the development of practice guidelines which can assist health service professionals in their efforts to improve the quality of care provided to our nation's 250,000 dialysis patients. Dialysis clinics need this reimbursement update in order to be able to implement these recommendations.

Sincerely,

JOHN DAVIS,
CEO.

THE GLAUCOMA FOUNDATION,
October 19, 2000.

Hon. DENNIS HASTERT,
U.S. Congressman, U.S. House of Representatives, Washington, DC.

DEAR MR. SPEAKER: I am writing to urge your support of section 105 of the Ways and Means Committee Budget Refinement Package for Medicare. This provision provides for screening for glaucoma, the nation's leading cause of preventable blindness, for those at risk. The Glaucoma Foundation supports this forward-looking initiative, which will help preserve the precious gift of sight.

Sincerely,

JOHN W. CORWIN,
Executive Director.

JUVENILE DIABETES FOUNDATION INTERNATIONAL, THE DIABETES RESEARCH FOUNDATION.

Hon. J. DENNIS HASTERT,
Speaker of the House, House of Representatives, Washington, DC.

DEAR MR. SPEAKER. I write on behalf of the Juvenile Diabetes Foundation International (JDF) regarding the Balanced Budget Act ''Givebacks'' bill that is currently under consideration.

The legislation contains three years of funding for critically important diabetes programs. The bill increases funding to $100 million for the special juvenile diabetes research program created in the Balanced Budget Act of 1997 and extends the program's funding through fiscal year 2003. The bill provides the same level of funding for the Native American diabetes program.

JDF strongly supports these provisions in the bill and we urge its approval. As you know, JDF has been pursuing at least five years of funding for these programs to provide a more stable stream of resources that can be most efficiently used by scientists. We encourage you to extend these programs through at least 2005 to make them even more effective in our battle against diabetes.

Mr. Speaker, on behalf of the JDF and everyone whose lives have been impacted by diabetes, we want to thank you for your leadership in promoting these important diabetes initiatives, and we look forward to continuing to work with you in our battle to cure this devastating disease.

Sincerely,

LEAH MULLIN,
Chairman, Government Relations.

NATIONAL MULTIPLE SCLEROSIS SOCIETY,
Washington, DC, October 19, 2000.

Hon. TRENT LOTT,
U.S. Senate,
Hon. DENNIS HASTERT,
House of Representatives, Washington, DC.

DEAR MAJORITY LEADER LOTT AND SPEAKER HASTERT: The National Multiple Sclerosis Society supports legislation to increase Medicare payments to health care providers. We strongly advocate that members of Congress vote for this legislation, and that the President sign it into law. Medicare reimbursements to health care providers must be increased so that beneficiaries with chronic conditions will have access to necessary health care services.

In addition to increasing access to Medicare health care services, we are also concerned about restoring Medicare coverage for self-injectible drugs and biologicals to beneficiaries who are unable to self-administer. There are three FDA approved self-injectible drugs that can alter the course of the disease, and slow the onset and progression of physical disabilities, Avonex, Betaseron and Copaxone. Each drug annually costs $10,000 to $12,000. The National MS Society recommends that patients diagnosed with relapsing-remitting MS begin taking one of these drugs immediately after diagnosis, and stay with the therapy.

Prior to 1997, Medicare carriers had the discretion to determine whether reimbursement was appropriate for self-injectible drugs, if they were administered incident to a physician's care. Since 1997, when Medicare terminated Medicare coverage for self-injectibles, we have worked to restore this coverage arguing that MS patients often experience temporary or permanent physical disabilities that make it very difficult, if not impossible, to self-administer these drugs.

Our understanding is that language in the Medicare bill begins to address this problem. However, the language does not go far enough. The self-injectible provision continues to rely on drug labeling rather than the beneficiary's ability to self-inject. This language leaves many MS beneficiaries without coverage when they are physically unable to self-inject necessary treatments that help to slow the progress of their disease. We believe that if a physician determines that the patient cannot self-inject, then Medicare should cover the drug.

The National Multiple Sclerosis Society, established in 1946, is dedicated to ending the devastating effects of multiple sclerosis. Multiple sclerosis is an often progressive, degenerative disease of the central nervous system that affects one-third of a million Americans. Symptoms may be mild, such as numbness in the limbs, or severe, such as paralysis or loss of vision.

Please let us know if we can provide any additional information on administration of

self-injectible drug and biologicals or be helpful in any other way.

Sincerely,

MIKE DUGAN,
President and CEO.

AMERICAN COLLEGE OF GASTROENTEROLOGY,
Arlington, VA, October 19, 2000.

Hon. WILLIAM V. ROTH, JR.,
Chairman, Committee on Finance, Dirksen Senate Office Building, Washington, DC.

DEAR CHAIRMAN ROTH: The American College of Gastroenterology (ACG) wants to be among the first to applaud you and the other Members of the Senate and House of Representatives for your work in shaping fair and equitable Medicare-related provisions for the pending Balanced Budget Act legislation. Although in the short time afforded us to review the bill, we have not had the chance to evaluate all aspects and ramifications of all the provisions of the legislation, we are particularly supportive and appreciative that the current bill includes an important provision that will enhance the Medicare colorectal cancer screening benefit to offer for the first time beneficiaries who are at average risk of colorectal cancer the option of receiving a colonoscopy once every ten years, instead of a flexible sigmoidoscopy every four years. This is a very essential step forward in advancing patient options and public health.

As you know, we remain deeply concerned about the site-of-service problem for those procedures with less than 10% office volume, and particularly the lower and inadequate physician professional fee for those services that are performed in a Medicare-certified ambulatory surgery center, or the hospital outpatient department. We are also concerned that so few Medicare beneficiaries are availing themselves of the cancer screening benefit you have so wisely provided. With only 1% of Medicare beneficiaries actually using this preventive benefit, according to GAO, we continue to believe that this benefit will fall far short of its potential and that the proposed new study in Section 411 is more likely to delay and possibly confuse the problem. Just as we learned with pap smears and cervical cancer, we believe if will be necessary for Congress to intervene to reverse a HCFA-driven economic/reimbursement policy which serves to undercut the Medicare colorectal cancer benefit by financially penalizing physicians who perform colorectal cancer screenings.

We look forward to working with you at the earliest appropriate time to deal with the site-of-service issue and find ways to increase the use of these life-saving screenings.

Very truly yours,

ROWEN K. ZETTERMAN, M.D., FACS,
President.

FEDERAL AFFAIRS DIVISION,
AMERICAN ACADEMY OF OPHTHALMOLOGY,
Washington, DC, October 19, 2000.

Hon. WILLIAM M. THOMAS,
Chairman, House Ways and Means Subcommittee on Health, Longworth House Office Building,
Washington, DC.

DEAR CHAIRMAN THOMAS: The American Academy of Ophthalmology congratulates you on completion of a Medicare refinement and benefits improvement bill and we call on Congress to quickly pass the Medicare Refinement and Benefits Improvement Act of 2000.

Although we are disappointed that the committee did not include the much needed relief for specialists from Medicare practice expense cuts scheduled for 2001, we hope to work with you next year to get the Health Care Financing Administration (HCFA) to make the refinements necessary to protect beneficiaries' access to life saving and sight saving procedures that have been adversely impacted. The practice expense cuts come on top of a decade of cuts that speciality physicians like ophthalmologists have experienced in an effort to protect the solvency of the Medicare program. The committee's decision to include several new Medicare benefits and other program improvements for beneficiaries, however, is highly significant and must be commended.

Specifically, this bill reaches out to our nation's seniors to help preserve their sight and independence by providing a glaucoma detection eye examination once every two years to those beneficiaries at high risk of developing glaucoma such as African Americans and those with a family history.

It is time to address the devastating effects of glaucoma. The scientific verdict is in—treatment for glaucoma is effective and can preserve sight and quality of life. An estimated 120,000 Americans are legally blind due to glaucoma, and estimates show at least 2 to 3 million people have glaucoma although half are not aware of it. Glaucoma affects 2 to 3 percent of the nation's seniors and another 5 to 10 million individuals have elevated intraocular pressure—a risk factor for developing glaucoma. African Americans are six to eight times more likely to develop glaucoma than other populations. Other risk factors include family history and advanced age.

Early detection is the key to saving sight and this bill helps those who need it. The Academy is pleased to support the Medicare Refinement and Benefits Improvement Act of 2000.

Sincerely,

WILLIAM L. RICH III, MD,
Secretary for Federal Affairs.

PRESIDENT,
AMERICAN OPTOMETRIC ASSOCIATION,
St. Louis, MO, October 19, 2000.

Hon. WILLIAM V. ROTH, JR.,
U.S. Senate, Washington, DC.

DEAR SENATOR ROTH: The American Optometric Association applauds your efforts to include new and important benefits in the pending Medicare Refinement Package. The American Optometric Association (AOA) represents the interests of more than 30,000 Doctors of Optometry and their patients.

We are particularly pleased that the glaucoma eye examination benefit is a part of this package. This bi-partisan supported provision is an important step in preventing blindness due to undetected glaucoma. The National Eye Institute has estimated that almost three million Americans have glaucoma. Half of these people are not aware that they have the disease. Of those who have been diagnosed with glaucoma, about 120,000 are blind. Moreover, glaucoma is a leading cause of blindness in older adults. Although glaucoma can often be controlled if it is diagnosed early, in may Americans the disease goes untreated, leading to visual impairment or blindness. Because there are no early warning signs, this disease often develops undetected until permanent vision loss has occurred.

Again, the AOA appreciates inclusion of this important preventive service in the Medicare Refinement and Benefits Improvement Act. It is an important part of ongoing efforts to improve public health and prevent unnecessary vision loss.

Sincerely,

HOWARD J. BRAVERMAN, O.P.

THE AMERICAN DIETETIC ASSOCIATION,
CHICAGO, IL, OCTOBER 19, 2000.

Hon. BILL ROTH, *Chairman,*
Hon. DANIEL PATRICK MOYNIHAN,
Senate Finance Committee, Washington, DC.
Hon. BILL ARCHER, *Chairman,*
Hon. CHARLES RANGEL,
House Ways and Means Committee, Washington, DC.
Hon. TOM BLILEY, *Chairman,*
Hon. JOHN DINGELL,
House Commerce Committee, Washington, DC.
Hon. BILL THOMAS, *Chairman,*
Hon. PETE STARK,
Health Subcommittee, House Ways and Means Committee, Washington, DC.
Hon. MIKE BILIRAKIS, *Chairman,*
Hon. SHERROD BROWN,
Health Subcommittee, House Commerce Committee, Washington, DC.

DEAR CHAIRMAN AND RANKING MEMBERS: The American Dietetic Association is pleased to support the Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 which provides critical support to Medicare providers while enhancing benefits for our nation's senior citizens. In particular, we are pleased that the legislation includes coverage of medical nutrition therapy for patients with diabetes and kidney disease. We believe this is an important first step in providing this critical service to all Medicare beneficiaries and we urge enactment of this legislation.

Nutrition therapy has been shown to be effective in the management and treatment of many chronic conditions which affect Medicare beneficiaries, including dyslipidemia, hypertension, heart failure, diabetes and chronic renal insufficiency. Medicare beneficiaries undergoing cancer treatment may also benefit from nutrition therapy aimed at controlling side effects or improving food intake. In fact, a recent study, conducted by the National Academy of Sciences Institute of Medicare and requested by Congress in the Balanced Budget Act of 1997, concluded that medical nutrition therapy—upon physician referral—should be a covered benefit under the Medicare program.

The 70,000 members of the American Dietetic Association look forward to working with you to ensure that all Medicare beneficiaries have access to medical nutrition therapy and, as a result, see a significant improvement in their health and quality of life.

Sincerely,

JANE V. WHITE, PHD, RD, LDN
President.

October 19, 2000.

Hon. WILLIAM V. ROTH, Jr.,
Senate Finance Committee, U.S. Senate, Washington, DC.

DEAR CHAIRMAN ROTH: The American Association of Blood Banks, America's Blood Center, and the American Red Cross would like to express our support for the Medicare, Medicaid and SCHIP Beneficiary Protection and Improvement Act of 2000. We are pleased that Section 301 of the final conference agreement contains both the House and Senate provisions concerning blood and blood products. We would especially like to thank you, Senator Hatch and Chairman Thomas for your tremendous leadership on blood safety and reimbursement concerns.

The blood banking community believes the House provision pertaining to blood is needed to ensure that the Health Care Financing Administration accurately reflects the costs of blood and blood products in the next revision of inpatient reimbursement rates. The Senate provision is needed to ensure that the current system will be able to account for future blood safety costs in a timely manner.

We are delighted that the final package contains both these provisions. We strongly support Congressional enactment of the legislation and urge the President to sign the bill into law.

Once again, we appreciate and commend your efforts to address reimbursement for blood and blood products in legislation this year. Your efforts will help ensure that patients across the country have access to state-of-the-art blood products and services and the safest possible blood supply.

Sincerely yours,

American Association of Blood Banks,
America's Blood Centers,
American Red Cross.

ADVANCED MEDICAL TECHNOLOGY ASSOCIATION,
Washington, DC, October 20, 2000.

Hon. BILL THOMAS,
Chairman, Ways and Means Subcommittee on Health, Washington, DC.

DEAR CHAIRMAN THOMAS: On behalf of the Advanced Medical Technology Association (AdvaMed), its more than 800 member companies, and the millions of Medicare patients whose lives are saved and improved by our innovative medical tests and treatments each year, I am writing to endorse the Medicare Refinements legislation now before Congress. This bill takes important, needed steps to strengthen the program and ensure seniors' access to quality health care. We hope that the President will sign it into law.

The Medicare Refinements package will protect seniors' access to important medical services and expand and establish new preventive health benefits like screening for cervical cancer, colorectal cancer, and glaucoma.

Building on important first steps taken in the Balanced Budget Refinement Act of 1999, the bill includes additional changes to improve seniors' health by ensuring access to the latest advances in medical technology. Key provisions in this area will:

Create new payment and coding mechanisms to improve access to new hospital inpatient technologies;

Establish special payment categories for innovative medical devices under the new hospital outpatient payment system;

Mandate special methods to pay for breakthrough diagnostic tests and require Medicare to set clear, open procedures for coding and payment decisions;

Require Medicare to issue annual reports to Congress on how long it takes to make coverage, coding, and payment decisions; and

Strengthen seniors' right to appeal a noncoverage decision for a new medical technology.

Once enacted, these provisions will ensure that all seniors, regardless of where they seek medical treatment, have access to the life-saving and life-enhancing technologies and procures they need.

It would be a disservice to the 39 million seniors and people with disabilities who will benefit from your Medicare bill if I did not bring to your attention now a separate Medicare patient access issue. We just learned from HCFA on October 18th that outpatient ''pass-through'' payments for new medical technologies and medicines will be cut by 50% on Jan. 1, 2001. The Agency is taking this action despite its prior commitment in an April 7 regulation not to consider any cuts until 2002.

These severe and unexpected payment reductions could significantly restrict patients' ability to receive innovative treatments in this setting, forcing them to receive more costly and time-consuming inpatient procedures. The late hour at which HCFA disclosed these cuts and the serious implications they hold for Medicare patient access to medical technology compel me to raise the issue at this time. We hope that you will encourage HCFA to administratively delay these reductions until 2002 when the agency has had time to gather more complete data.

We greatly appreciate the sustained efforts you are making to oversee the Medicare program and make sure it continues to deliver essential health care services to seniors in the 21st century. Your work will greatly benefit the millions of seniors and people with disabilities who are covered by this program in the years to come.

Thank you for your leadership in this area. We wholeheartedly support your efforts to ensure seniors get the health care services they need and look forward to continuing to work with you toward this goal.

Sincerely,

PAM BAILEY.

GE MEDICAL SYSTEMS,
GENERAL ELECTRIC COMPANY,
Milwaukee, WI, October 19, 2000.

Hon. J. DENNIS HASTERT,
Office of the Speaker of the House, Washington, DC.

Hon. TRENT LOTT,
Office of the Senate Majority Leader, Washington, DC.

DEAR SPEAKER HASTERT AND MAJORITY LEADER LOTT: GE Medical Systems strongly supports the Medicare Balanced Budget Refinement Leadership Compromise Package that provides for differential reimbursement for new technology associated with screening mammography.

GE Medical Systems—a global leader in medical diagnostic equipment, services, and health care information management—is committed to ensuring that Medicare beneficiaries have access to breast cancer screening using the latest advances in medical technology. In partnership with the U.S. government, we have invested significant resources in the development of digital mammography technology that holds the promise for dramatically improving patient outcomes through early detection and diagnosis of breast cancer. The compromise package provides for adjustment of Medicare payment rates for screening mammography to reflect the costs associated with new technology advances like digital mammography.

We welcome the opportunity to work with the leadership to ensure that access to the benefits of digital mammography technology is a reality for Medicare beneficiaries. Thank you for your support of this important initiative.

Sincerely,

JEFF IMMELT.

To: The Honorable William J. Clinton, President.

Date: October 19, 2000.

Subject: Medicare Refinement Package.

As a representative of Tenet Healthcare Corporation, I want to inform you of our support for final passage of the Medicare Refinement Package being advocated by Congress. While we fully understand and agree with your position that hospitals should get a fairer share of the restoration funds, we fear any delay may impede final passage of any Medicare restoration. As you are well aware, hospitals would suffer severely from lower reimbursements that would result.

For the last two years, many others and I have spent significant time and effort in asking Congress to restore funding reduced by the draconian cuts imposed in 1997. We have demonstrated the short and long range negative effects on the overall quality and stability of our industry as a result of the cuts. We greatly fear that the health care industry may not be capable to meet the needs of the public, much less the increased demand of the baby boomer generation. We have been able to convince a large number of members to begin to restore funding both in 1999 and this year. While the restorations are not significant compared to the cuts, they are at least a move in the right direction.

This year we had at least hoped to receive more than one year of restoration, but settled in recent days for one year, appreciative of the Medicare and Medicaid DSH increases and the 70% bad debt allowances. We fear any last minute efforts may deter the final package. As we said before, this would be devastating. Therefore, while we appreciate your efforts to provide hospitals a more equitable share of the restoration, we ask you to assure passage of the bill this session.

Thank you for your interest.

Sincerely,

PHYLLIS LANDRIEU.

ASSOCIATION OF SURGICAL TECHNOLOGISTS,
Englewood, CO, October 19, 2000.

Hon. DENNY HASTERT,
Speaker of the House, House of Representatives, Washington, DC.

Hon. TRENT LOTT
Majority Leader, U.S. Senate, Washington, DC.

DEAR SPEAKER HASTERT AND MAJORITY LEADER LOTT: This letter is written in support of the agreement you have reached on Medicare and Medicaid refinement legislation. As you know, this bill makes a number of important changes that will greatly enhance the ability of hospitals to continue to delivery high-quality, cost-effective health care.

We are urging your colleagues in the House and Senate to support your package of changes and we are also asking President Clinton to support this package as well. We believe it is extremely important that Congress and President Clinton act on your proposal as quickly as possible.

This legislation represents a major improvement in the Medicare and Medicaid programs for both providers and beneficiaries. Your hard work and dedication to improving Medicaid is greatly appreciated.

Sincerely,

WILLIAM TEUTSCH, CAE, CEO,
Executive Director.

OCTOBER 19, 2000.

Hon. J. DENNIS HASTERT,
Speaker, U.S. House of Representatives, Washington, DC.

DEAR MR. SPEAKER: The National Orthotics Manufacturers Association (NOMA) strongly supports the Medicare Refinement legislation pending in Congress that includes important provisions for the orthotic and prosthetic community. We are hopeful that the President will join the health care community and support this legislation.

Specifically, we support those provisions that establish standards for billing of prosthetics and a limited number of custom-fabricated orthotics, which should help bring greater fiscal integrity to the Medicare program and ensure that beneficiaries receive the appropriate O&P items that their physicians have ordered. As well, we applaud the equity of allowing O&P to receive a full CPI update for the first time in three years, since the limited updates granted since 1998 have not kept pace with inflation.

For these reasons, we respectfully encourage your office to ensure that these important provisions remain part of any final Medicare bill that is sent to the President.

Sincerely,

The National Orthotic Manufacturers Association (NOMA).

AMERICAN ORTHOTIC & PROSTHETIC ASSOCIATION,
OCTOBER 18, 2000.

Hon. J. DENNIS HASTERT,
Speaker, U.S. House of Representatives, Washington, DC.

DEAR MR. SPEAKER: The American Orthotic and Prosthetic Association (AOPA) strongly support the inclusion of certain provisions in the pending Medicare package that is of great interest to the O&P community.

Speficially, we support those provisions that establish standards for billing of prosthetics and custom orthotics, which will bring great fiscal integrity to the Medicare program. We believe the final payment language is a step in the right direction toward guaranteeing that Medicare beneficiaries receive the best care possible and the appropriate O&P items that their physicians have ordered, as well as implementing the recommendations of the HHS Office of Inspector General and addressing the fraud and abuse of the Medicare payment system.

Also, we applaud the equity of allowing O&P to receive a full CPT update for the first time in three years, since the limited updates granted since 1998 have not kept pace with inflation. Finally, we support all legislative efforts which work toward improving the negative impact on the frail disabled which has resulted from the Health Care Financing Administration's (HCFA) issuance of Ruling 96–1, and we look forward to the results of the study included in the bill.

For these reasons, we respectfully encourage your office to ensure that these important provisions remain part of any final Medicare bill that is sent to the President.

This is important legislation, and AOPA hopes the President will sign it.

Sincerely,

President, American Orthotic and Prosthetic Association.

UBS WARBURG,
New York, NY, October 19, 2000.

Hon. J. DENNIS HASTERT,
Speaker of the House of Representatives, Capitol Building, Washington, DC.

DEAR MR. SPEAKER: We appreciate your time and leadership to date in structuring national Medicare benefit and spending refinements. As always, we appreciate your willingness to listen to our thoughts on Medicare. We cannot stress how important the current leadership's Medicare and Medicaid relief package proposal is to healthcare providers, and to investors. We are concerned about the potential for the Medicare relief package to be de-railed by politics. Such an unfortunate scenario would, in our view, damage any private sector (investor) faith in the Medicare system that has been restored since the original Balanced Budget Act of 1997, if such faith deteriorates again, we do not believe the private sector will continue to meaningfully fund the healthcare industry, the government would end up spending exponentially more to provide care, and quality of care could be jeopardized in the near-term.

Medicare spending has been almost frozen over the last three fiscal years, and that (along with intended and unintended cuts) has taken its toll on the provider system. According to MEDPAC, roughly 35% of all hospitals are losing money on Medicare and another 31% are surviving with less than a 2% profit margin. We estimate that 18% of all skilled nursing beds are operating under Chapter 11 protection, and that 10% of all home health and hospice agencies have closed or exited the business over the past 18 months. To put this in financial terms, roughly $60 to $80 billion of value (equity and debt) has been lost—most of this by investors and lenders.

In short, we believe the very care of the healthcare delivery system (a system that has historically relied on private sector investment to meet its capital needs) is at risk of losing this essential, primary funding source. It is critical that the pending Congressional package of broad Medicare and Medicaid benefit and spending refinements is enacted before Congress adjourns. No legislation is perfect, however, the current package is good and offers necessary progress toward resuscitating healthcare providers and establishing investor confidence in the sectors. We hope and anticipate that next year's Congress will continue the progress to date and address other structural Medicare issues. But for now, please focus your efforts on passing the existing package.

We appreciate your leadership in restoring confidence and solvency to healthcare delivery and your time in weighing our views and recommendations. As always, we welcome any opportunity to further discuss these issues with you and your staffs.

Sincerely,

HOWARD G. CAPEK,
Executive Director, U.S. Healthcare Services Research.

MATTHEW J. RIPPERGER,
Director, U.S. Healthcare Services Research.

Mr. Speaker, let me just say this is not the best tax relief bill in the world. I think the best tax relief bill in the world would reduce taxes on everyone. But we have seemed to have got even ourselves in the habit of saying we want to give tax relief only to the right people, which is an incredibly arrogant position for us to find ourselves in, that we would pick and choose the people in America who are the right people for tax relief.

For example, we have heard in campaigns this year that people who have photovoltaic cells in their roofs are the right people and they can get in line; people that drive hydroelectric cars are the right people, they can get in line; people with a child under 1 year of age can get in line for tax relief, provided that child is in a day care center approved by the government.

We ought not be picking and choosing winners and losers. As representatives of all the American people, we ought to set policy everybody can succeed in, create opportunities for everyone to do well, and we ought not ever again be able to say we are only giving tax relief to the right people.

I think this is a good start in helping small businesses, but it should go to everyone. We should have let people deduct insurance, medical insurance, whether they were a large corporation or small business, a long time ago. This is a step in the right direction to do that.

Mr. Speaker, I strongly urge my colleagues to support the previous question, support the rule.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. LEACH).

Mr. LEACH. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise to alert the House that there is a provision in this statute that I think is of seminal significance for the small business community.

Since 1933, there has been a prohibition in the banking industry on the capacity of banks to pay interest on demand deposits for business. In this bill is a repeal of that prohibition. For the first time small business in the United States will be allowed to receive interest on their checking accounts at depository institutions.

It is a phased-in circumstance over several years, with, at the beginning, a concept called sweep accounts involved, and then a complete prohibition comes into play.

But I would just simply alert the body that this provision is in this bill, and I would like to also express my deep appreciation of the leadership for allowing this very important banking bill to come under consideration at this particular time.

Mr. RUSH. Mr. Speaker, I rise to vote against the rule on H.R. 2614, the Certified Development Program Improvements Act. On September 26, 2000, the House Commerce Committee approved the Beneficiary Improvement Protection Act of 2000, H.R. 5291. This bill was the result of extensive bipartisan negotiations between committee Members. Both Republicans and Democrats sat down at the same table and worked through their differences to forge a bill which addressed the concerns of hospitals, HMOs, home health networks and other providers.

Despite the differences of opinion amongst the various Members, we worked through our disagreements and passed a bill that had broad bipartisan support. I want to commend my colleagues on both sides of the Commerce Committee for their tireless efforts on that bill.

However, instead of building on the bipartisan efforts of the Commerce Committee, the Republican majority chose to go its own way and start from scratch. One month after the Commerce Committee acted, Democrats have been waiting for the Republican majority to bring us into negotiations, to recognize our willingness to compromise and to extend us the same courtesy. Last Friday, we received a document that looked nothing like the bill forged by the bipartisan efforts of the Commerce Committee. Aggravating this situation, the Republican majority has made it clear that they are not interested in entering into true negotiations on their bill. Rather they have chosen to squander this opportunity by using the calendar to pressure Members into agreeing to a ''quick fix.'' Each day the majority places one or two provisions back into the bill in an attempt to pressure enough Members who would rather obtain some relief, than nothing at all.

This approach is unacceptable. In Illinois, neither HMO's nor hospitals can wait another session for relief. This situation is not unique to Illinois, I know many of you are hearing daily from your seniors and health care providers who are pleading for relief. For the foregoing reasons, I must vote against this rule.

Mr. LINDER. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

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

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

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9, rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of agreeing to the resolution.

The vote was taken by electronic device, and there were—yeas 209, nays 195, not voting 29, as follows:

[Roll No. 555]

YEAS—209

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bereuter
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Foley
Fossella
Fowler
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
King (NY)
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
Martinez
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Morella
Myrick
Nethercutt
Northup
Norwood
Nussle
Ose
Oxley
Paul
Pease
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Scarborough
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Traficant
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NAYS—195

Abercrombie
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Forbes
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gonzalez
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Markey
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (WA)
Snyder
Stabenow
Stark
Stenholm
Strickland
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thurman
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watt (NC)
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOT VOTING—29

Ackerman
Blagojevich
Brady (PA)
Campbell
Chenoweth-Hage
Crowley
Danner
Engel
Franks (NJ)
Hoekstra
Klink
LaTourette
Lazio
McCollum
McIntosh
Metcalf
Neal
Ney
Owens
Packard
Peterson (PA)
Shays
Spratt
Stupak
Talent
Thompson (MS)
Waxman
Weiner
Weldon (PA)

☐ 1258

Mr. TIERNEY and Mr. KUCINICH changed their vote from ''yea'' to ''nay.''

Mr. MCKEON changed his vote from ''nay'' to ''yea.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. BURR of North Carolina). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. MOAKLEY. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 207, noes 200, not voting 26, as follows:

[Roll No. 556]

AYES—207

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bereuter
Biggert
Bilbray
Bilirakis
Bliley
Blunt
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Cubin
Cunningham
Davis (VA)
Deal
DeLay
DeMint
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ewing
Fletcher
Foley
Fossella
Fowler
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Green (WI)
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (MT)
Hilleary
Hobson
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Isakson
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones (NC)
Kasich
Kelly
Kingston
Knollenberg
Kolbe
Kuykendall
LaHood
Largent
Latham
Leach
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
Martinez
McCrery
McInnis
McKeon
Mica
Miller (FL)
Miller, Gary
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Ose
Oxley
Paul
Pease
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Regula
Reynolds
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryan (WI)
Ryun (KS)
Salmon
Sanford
Saxton
Scarborough
Schaffer
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simpson
Skeen
Smith (MI)
Smith (TX)
Souder
Spence
Stearns
Stump
Sununu
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Traficant
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weller
Whitfield
Wicker
Wilson
Wise
Wolf
Young (AK)
Young (FL)

NOES—200

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blumenauer
Boehlert
Bonior
Borski
Boswell
Boucher
Boyd
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello

Coyne
Cramer
Cummings
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Forbes
Ford
Frank (MA)
Frost
Gejdenson
Gephardt
Gonzalez
Gordon
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kleczka
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Maloney (CT)
Maloney (NY)
Markey
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHugh
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Smith (NJ)
Smith (WA)
Snyder
Stabenow
Stark
Stenholm
Strickland
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thurman
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watt (NC)
Weiner
Wexler
Weygand
Woolsey
Wu
Wynn

NOT VOTING—26

Blagojevich
Brady (PA)
Campbell
Chenoweth-Hage
Crowley
Danner
Engel
Franks (NJ)
Hoekstra
Klink
LaTourette
Lazio
Lewis (CA)
McCollum
McIntosh
Metcalf
Neal
Owens
Packard
Peterson (PA)
Spratt
Stupak
Talent
Thompson (MS)
Waxman
Weldon (PA)

□ 1309

Mr. HORN changed his vote from ''no'' to ''aye.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate has passed without amendment a bill of the House of the following title:

H.R. 5178. An act to require changes in the bloodborne pathogens standard in effect under the Occupational Safety and Health Act of 1970.

The message also announced that the Senate has passed with amendment in which the concurrence of the House is requested, a bill of the House of the following title:

H.R. 2498. An act to amend the Public Health Service Act to provide for recommendations of the Secretary of Health and Human Services regarding the placement of automatic external defibrillators in Federal buildings in order to improve survival rates of individuals who experience cardiac arrest in such buildings, and to establish protections from civil liability arising from the emergency use of the devices.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 2335

Mr. INSLEE. Mr. Speaker, I ask unanimous consent to remove my name as a cosponsor of H.R. 2335.

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

There was no objection.

WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 4942, DISTRICT OF COLUMBIA APPROPRIATIONS ACT, 2001

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 653 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 653

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 4942) making appropriations for the government of the District of Columbia and other activities chargeable in whole or in part against the revenues of said District for the fiscal year ending September 30, 2001, and for other purposes. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read.

The SPEAKER pro tempore. The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST), pending which I yield myself such time as I might consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, H. Res. 653 is a typical rule providing for consideration of H.R. 4942, the conference report for the District of Columbia Appropriations Act for fiscal year 2001. The rule waives all points of order against the conference report and its consideration, and provides that the conference report shall be considered as read.

The House rules provide 1 hour of general debate, divided equally between the chairman and ranking minority member of the Committee on Appropriations, and one motion to recommit, with or without instructions, as is the right of the minority members of the House.

I want to briefly discuss the conference report that this rule makes in order. The conference report appropriates $445 million for the District of Columbia, and it appropriates $37.5 billion for the Departments of Commerce, Justice and State, the Federal Judiciary, and 18 related agencies.

□ 1315

For the District of Columbia, the bill provides $17 million for the college assistance, $5 million to help move children from foster care to adoptive families, $1 million for pediatric health clinics, and provides for the largest ever drug testing and treatment program. These appropriations go directly to improving the lives of the District's residents.

The bill provides a $384 million increase for the DEA, the FBI, and the U.S. Attorneys to ensure that our Federal law enforcers have the tools that they need in the 21st century. The bill provides an additional $548 million for the Immigration and Naturalization Service to ensure the safety of our borders and the efficiency of our immigration process.

For local and State law enforcement, the bill appropriates $4.7 billion, a total that includes dollars for law enforcement block grants and funding for Violence Against Women Act programs.

Equally important for the safety of our people, the bill provides the State Department with $6.9 billion. This total, more than the President requested, will ensure worldwide security improvements at our embassies to ensure the safety of U.S. personnel. The bill also provides full funding for our current year United Nations assessments.

I might add, it is the gentleman from Kentucky (Mr. ROGERS), chairman for the subcommittee, whose own interest in worldwide safety of our embassies has held sway in all of these debates and provided the funding for these embassies.

Mr. Speaker, I am sad to say that I have heard that the President intends to veto this bill, he intends to stop this money for local law enforcement, money for Federal law enforcement, money for the residents of the District of Columbia, money for the safety of our embassies, and money for the United Nations.

Mr. Speaker, do my colleagues know why he has threatened to veto this bill? Because it does not contain language to provide mass amnesty for those who have flouted U.S. law and come to this country illegally. Such language was not included in the House-passed bill. Such language was not included in any Senate version. Yet, the President today seems to be insisting that it is his way or the highway.

He seems to be saying today that he wants to provide amnesty to law breakers rather than provide funding to law enforcers. Rather than provide the funding to those who protect our borders, he wants to provide amnesty