

problematic provisions relating to the generalized system of preferences that were in the original House-passed bill.

For all these reasons, Mr. Speaker, I urge support of H. Res. 1341.

Ms. ROS-LEHTINEN. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. BERMAN) that the House suspend the rules and agree to the resolution, H. Res. 1341.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

RESIGNATION AS MEMBER OF COMMITTEE ON SCIENCE AND TECHNOLOGY

The SPEAKER pro tempore laid before the House the following resignation as a member of the Committee on Science and Technology:

JULY 14, 2008.

Hon. NANCY PELOSI,
Speaker, House of Representatives,
Washington, DC.

DEAR SPEAKER PELOSI: I hereby resign my seat on the Committee on Science and Technology, effective July 14, 2008. It has been a pleasure to serve on this committee.

Sincerely,

PAUL E. KANJORSKI,
Member of Congress.

The SPEAKER pro tempore. Without objection, the resignation is accepted.

There was no objection.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 2 o'clock and 6 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 1434

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Ms. ROYBAL-ALLARD) at 2 o'clock and 34 minutes p.m.

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008—VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 110-131)

The SPEAKER pro tempore laid before the House the following veto message from the President of the United States:

To the House of Representatives:

I am returning herewith without my approval H.R. 6331, the "Medicare Im-

provements for Patients and Providers Act of 2008." I support the primary objective of this legislation, to forestall reductions in physician payments. Yet taking choices away from seniors to pay physicians is wrong. This bill is objectionable, and I am vetoing it because:

It would harm beneficiaries by taking private health plan options away from them; already more than 9.6 million beneficiaries, many of whom are considered lower-income, have chosen to join a Medicare Advantage (MA) plan, and it is estimated that this bill would decrease MA enrollment by about 2.3 million individuals in 2013 relative to the program's current baseline;

It would undermine the Medicare prescription drug program, which today is effectively providing coverage to 32 million beneficiaries directly through competitive private plans or through Medicare-subsidized retirement plans; and

It is fiscally irresponsible, and it would imperil the long-term fiscal soundness of Medicare by using short-term budget gimmicks that do not solve the problem; the result would be a steep and unrealistic payment cut for physicians—roughly 20 percent in 2010—likely leading to yet another expensive temporary fix; and the bill would also perpetuate wasteful overpayments to medical equipment suppliers.

In December 2003, when I signed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) into law, I said that "when seniors have the ability to make choices, health care plans within Medicare will have to compete for their business by offering higher quality service. For the seniors of America, more choices and more control will mean better health care." This is exactly what has happened—with drug coverage and with Medicare Advantage.

Today, as a result of the changes in the MMA, 32 million seniors and Americans with disabilities have drug coverage through Medicare prescription drug plans or a Medicare-subsidized retirement plan, while some 9.6 million Medicare beneficiaries—more than 20 percent of all beneficiaries—have chosen to join a private MA plan. To protect the interests of these beneficiaries, I cannot accept the provisions of this legislation that would undermine Medicare Part D, reduce payments for MA plans, and restructure the MA program in a way that would lead to limited beneficiary access, benefits, and choices and lower-than-expected enrollment in Medicare Advantage.

Medicare beneficiaries need and benefit from having more options than just the one-size-fits-all approach of traditional Medicare fee-for-service. Medicare Advantage plan options include health maintenance organizations, preferred provider organizations, and private fee-for-service (PFFS)

plans. Medicare Advantage plans are paid according to a formula established by the Congress in 2003 to ensure that seniors in all parts of the country—including rural areas—have access to private plan options.

This bill would reduce these options for beneficiaries, particularly those in hard-to-serve rural areas. In particular, H.R. 6331 would make fundamental changes to the MA PFFS program. The Congressional Budget Office has estimated that H.R. 6331 would decrease MA enrollment by about 2.3 million individuals in 2013 relative to its current baseline, with the largest effects resulting from these PFFS restrictions.

While the MMA increased the availability of private plan options across the country, it is important to remember that a significant number of beneficiaries who have chosen these options earn lower incomes. The latest data show that 49 percent of beneficiaries enrolled in MA plans report income of \$20,000 or less. These beneficiaries have made a decision to maximize their Medicare and supplemental benefits through the MA program, in part because of their economic situation. Cuts to MA plan payments required by this legislation would reduce benefits to millions of seniors, including lower-income seniors, who have chosen to join these plans.

The bill would constrain market forces and undermine the success that the Medicare Prescription Drug program has achieved in providing beneficiaries with robust, high-value coverage—including comprehensive formularies and access to network pharmacies—at lower-than-expected costs. In particular, the provisions that would enable the expansion of "protected classes" of drugs would effectively end meaningful price negotiations between Medicare prescription drug plans and pharmaceutical manufacturers for drugs in those classes. If, as is likely, implementation of this provision results in an increase in the number of protected drug classes, it will lead to increased beneficiary premiums and copayments, higher drug prices, and lower drug rebates. These new requirements, together with provisions that interfere with the contractual relationships between Part D plans and pharmacies, are expected to increase Medicare spending and have a negative impact on the value and choices that beneficiaries have come to enjoy in the program.

The bill includes budget gimmicks that do not solve the payment problem for physicians, make the problem worse with an abrupt payment cut for physicians of roughly 20 percent in 2010, and add nearly \$20 billion to the Medicare Improvement Fund, which would unnecessarily increase Medicare spending and contribute to the unsustainable growth in Medicare.

In addition, H.R. 6331 would delay important reforms like the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies competitive bidding program, under which lower payment