ability to afford it. H.R. 6331 will keep our doctors in business so that our Nation's poor and elderly can get the health care that they need.

I am proud of the fact that H.R. 6331 contains some specific relief for folks in rural areas, making sure that rural doctors get paid fairly, increasing payments to critical access hospitals, and covering the additional fuel costs faced by ambulances in rural districts. This bill will also help poor seniors by increasing the amount of assets that a low-income beneficiary can have and still qualify for financial help with Medicare costs.

I recently spent a week touring just about every kind of health care facility in my district. Folks back home have a lot of problems with our health care system. While this bill doesn't fix everything that's broke with Medicare, it is a big step forward and we absolutely need it.

Mr. Speaker, we have until July 1 to stop these cuts from taking effect.

□ 1130

Unless we adopt this legislation before then, doctors all across the country will have to start turning away Medicare patients that they are seeing right now. We can't let that happen. I therefore urge my colleagues to support this bill.

I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I want to yield 2 minutes to a member of the Energy and Commerce Committee, the gentlewoman from Tennessee (Mrs. BLACKBURN).

Mrs. BLACKBURN. I thank the gentleman from Texas.

Mr. Speaker, he mentioned earlier in his comments the lack of hearings that we have had on this issue. Indeed, this morning over in Energy and Commerce there is a hearing on health issues, but nothing to do with Medicare reform, nothing to do with this situation that is before us right now. Indeed, late notice was mentioned.

Mr. Speaker, I think that what we see here is a pattern that is developing with the majority party, and when they don't want to talk about something, they don't want to debate it on the floor, they want to maybe cover a few things into the bill, then we have it on suspension calendar. I find that very unfortunate.

I will say this. With H.R. 6331, 89 percent of our seniors in Tennessee that are enrolled in Medicare Advantage would be adversely impacted by this bill. This is something, this bill, H.R. 6331, would leave a lot of our elderly patients and doctors in peril, while the leadership in this body is playing politics with Medicare.

We have heard about the 10 percent cut on July 1. We have heard about procrastinating and leaving this until the 11th hour rather than taking significant action. Mr. Speaker, I think that we have to look at what is happening to Medicare. I am deeply concerned about this issue and how it impacts our seniors.

We know that the Medicare trust fund is likely to go bankrupt in 2019. These aren't my figures, these are the Congressional Budget Office figures. We know that this year, we hit the 45 percent trigger, which occurs when Congress is obliged to find a new way to curb Medicare spending. This bill does not do one thing to curb that spending. It makes it worse. It is unfair to our seniors.

I urge a "no" vote.

Mr. STARK. Mr. Speaker, I yield myself 2 minutes.

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

Mr. STARK. Mr. Speaker, I urge my colleagues to support H.R. 6331. For whatever reasons, people may be concerned with process. To me, that is a snare and a delusion. Basically, this bill protects the physicians from their 10 percent cuts. If you vote against it, you're voting to cut physicians by 10 percent.

It improves benefits for seniors and people with disability, it ends discriminatory mental health copayments. So vote against the bill and seniors don't get mental health treatment. It targets extra help to low-income people. Vote against the bill and you're, as Republicans like to do, trashing low-income people for the benefit of rich insurance companies, the only one group that opposes this bill.

It delays the durable medical equipment competitive bidding demonstration, which we have agreed on a bipartisan basis should be delayed. Vote against the bill and let the medical equipment competitive bidding go ahead. It makes improvements in quick pay for pharmacists. Vote against the bill and talk to your local pharmacists, my Republican friends, and see what they think about your voting against the bill, which would otherwise provide them prompt payment.

The clinical labs, therapy services, rural providers, psychologists, social workers, dialysis patients all get help in this bill. So vote against it and go back and talk to your constituents who depend on those services for their quality of life.

I am ready to have you do that because all of this is paid for in a balanced, fair method, suggested, I might add, by the administration's own actuary, and the Government Accountability Office and MedPAC all say that trimming the payments to Medicare Advantage is the right thing to do, and will extend the life of the Medicare trust fund.

So it's not a bill I wish we were considering. The CHAMP Act, which many of you voted, is one. But this is a modest compromise. I urge its support.

For several years now, I have pushed to modernize Medicare's reimbursement for ESRD, consistent with longstanding recommendations from the Medicare Payment Advisory Commission, MedPAC, and the Government Accountability Office, GAO. The current payment system includes a perverse financial incentive to dose higher levels of the anti-anemia drug, Epogen, which can put patients at risk of death and serious cardiovascular events. Both MedPAC and GAO recommend replacing this system by reimbursing providers with one "bundled" payment for dialysis services and related drugs and labs, thereby removing the incentive to overuse items and services that are currently separately billed. This will encourage more efficient provider behavior while maintaining and improving patient care. This modernized payment system is consistent with the philosophy governing many of Medicare's other payment systems.

It is imperative bundling be done in a way that is sensitive to individual patient needs, protects against provider stinting, and is not "one-size-fits all." Including an outlier pool, risk adjustment, and a strong quality performance system all work to ensure that appropriate care is ensured.

That is why I was very proud when the Children's Health and Medicare Protection, CHAMP, Act, which passed the House in August 2007, advanced ESRD bundling with these patient protections. That is also why I am disheartened by the ESRD bundling proposal before us today, as I have several serious concerns with this package.

First, I am very disappointed to see that much of this package is designed to appease the profit-hungry interests of the dialysis and pharmaceutical companies. I have long believed that dialysis providers should meet strong quality standards in order to receive increased payments. I oppose the automatic updates in this bill. I hope that when structuring the quality incentive program, CMS pushes dialysis providers to meet a rigorous set of standards in order to get payment increases. In CHAMP, providers had to meet a clear and strong set of quality measures in order to receive bonus payment.

Unfortunately, the initial anemia management quality measure in this bill is seriously flawed. The MIPPA quality measure tells providers that they are providing acceptable care as long as they haven't gotten worse than their past track record. That's like telling a D-student that they are doing fine as long as they keep getting at least D grades.

This is wrong. We should be encouraging providers to improve the care provided. There are serious health issues at stake, with the FDA warning that using anti-anemia drugs in a way that raises red blood cell levels too high puts ESRD patients at risk of death or cardiovascular events. Sadly, the measure in MIPPA gives providers a pass as long as the care provided just doesn't get worse.

Instead, we should be encouraging providers to get more patients within FDA's recommended range for anemia management. We tried to do this in CHAMP when we designed something that pushed providers to at least meet the national average, with the bar getting raised in subsequent years. If the MIPPA quality measure is enacted into law, I intend to work to override or modify it. I hope that the Centers for Medicare and Medicaid Services will instead develop a system that pushes providers toward improved performance and assesses them against anemia management measures that are consistent with the FDA label.

A second flaw in this package is that it allows the large dialysis organizations, LDOs, to

benefit from a mandated low-volume adjustment. I have no problem with a low-volume adjustment if it is warranted and set right. However, LDOs don't need it, and they shouldn't get it. Repeated studies by the HHS Office of Inspector General show that LDOs are able to get much better prices on dialysis-related drugs than smaller dialysis organizations. Even if an LDO has a low-volume facility, that facility still benefits from the price discounts negotiated with the parent corporation. Giving LDOs a low-volume adjustment is an unnecessary waste of money.

Another flaw with the MIPPA package is that it only lets facilities fully opt-in to the bundled payment system in the first year of the phase-in. I suspect that facilities will find the incentives for practice patterns under the old system and new systems to be in conflict, and may quickly realize that moving directly to bundling in year two is easier. To the extent bundling incentivizes more efficient behavior and has the necessary patient protections, if a facility wants to opt-in in year two or three, I see no reason to stop them.

I would also like to clarify something about the bundle itself. MedPAC has repeatedly pushed for a broader ESRD bundle. My understanding of the MIPPA language is that it provides for inclusion of all oral dialysis-related drugs in the bundle, including calcimimetics and phosphate binders. Specifically the term "items and services" at clause (14)(B)(iv) of the Social Security Act, as amended by MIPPA, and the reference to "other drugs and biologicals" at clause (14)(B)(iii), both afford the Secretary broad discretion to include oral drugs furnished to an individual for the treatment of end stage renal disease that don't necessarily have an IV equivalent.

I know why some pharmaceutical companies want to exclude these drugs from the bundle. They want another product line where they can play their separately billable game and try to drive up utilization and corporate profits. That is contrary to the philosophy of bundling and not the intent of Congress.

These drugs should be included in the bundle to prevent cost shifting to Part D in order to circumvent the new bundled payment. Most importantly, it would ensure that decisions as to which drug a patient receives are driven by clinical decisions not reimbursement policy. This will also ensure that all drugs furnished to patients for the treatment of ESRD are captured in the new bundled payment.

I also believe the bundle should set in a way, including any appropriate adjustments, so that more frequent home dialysis, both peritoneal and hemodialysis, is adequately paid and encouraged.

ESRD bundling is long overdue, but it is unfortunate that industry has demanded such a high price for it. If this bill becomes law, I intend to keep pushing for these changes and will be watching and weighing-in heavily as CMS moves forward with implementation.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to address their remarks to the Chair.

Mr. CAMP of Michigan. I yield 1 minute to a respected physician, the gentleman from Louisiana (Mr. BOUSTANY).

Mr. BOUSTANY. I thank my colleague for yielding time to me.

As a physician, I am deeply disappointed in the way we are legislating on health care. Here we are, on one hand, physicians are facing a 10 percent cut in reimbursement, which is going to deeply have an impact on access. Furthermore, a 5 percent cut coming up in January. On the other hand, we are going to cut $47 billion out of a Medicare program that is extremely valuable to rural America.

I have a substantial number of citizens, constituents in my district, who depend on this program for access, not just coverage. Coverage is something on paper. Coverage gets you, hopefully, into the door, but not necessarily into the door of a physician's office where they can have a physician-patient relationship, a meaningful relationship that focuses on prevention and screening and not just treating everybody as if they are just a cog or an animal.

We want to do good health care, and this is an irresponsible way to do this. This bill does not pay attention to access; it simply glosses over it. It pits seniors, seniors against physicians. As a physician, I deeply resent that.

Mr. BARROW. Mr. Speaker, I am pleased to yield 1½ minutes to the distinguished chairman of the Committee on Energy and Commerce, the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I thank my good friend from Georgia, and I congratulate him on the way he is handling this legislation. We are proud of him and his service.

Mr. Speaker, the legislation before us today is critical to ensuring high quality physician services for Medicare beneficiaries. If you want to cabal about that, you're making a great mistake. If this legislation fails, physicians are going to face a 10 percent pay cut, and that is going to drive them out of Medicare and it's going to threaten the security and the health care of senior citizens and the disabled.

At the same time, this legislation provides additional protections for low-income beneficiaries, adds benefits to the traditional Medicare program, such as coverage for more preventive benefits. It will also address the Medicare drug benefit and make it work better for pharmacists and therefore seniors.

Finally, the legislation addresses one of the most egregious problems, and that is private plans operating in Medicare. Private Fee-for-Service plans, or PFFS plans, which is one type of Medicare Advantage plan. There, they are cutting a fat hog at the expense of the public. If you do away with that particular vice, you will find you are making it more solvent over a long period of time and you are using a mechanism which will help our senior citizens to know that their Medicare is protected and seeing to it that the doctors are there to provide the care that is needed. We are also assuring that the pharmacists are able to stay in this business by addressing a significant hurt that they are undergoing.

I urge my colleagues to support this legislation and not to cabal about the perfection of the process.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 30 seconds.

I think we are entitled to cabal about the process. We represent about 48 percent of the American people and have had absolutely no input into a multi, multibillion-dollar temporary fix. This would only go into effect for 1 year. It doesn't solve the long-term program. So I think we are entitled to a little caballing, as they said.

I want to yield 2 minutes to the distinguished gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. I thank the gentleman from Texas.

Florida 5 is the district that I represent, and it is not a wealthy area. I have the highest number of people on Social Security of any Member of this Congress, and obviously a huge number on Medicare.

Medicare Advantage is a very popular program. And why is it popular? It's popular because many of the programs, and by the way, there's a large variety of programs for the seniors to choose from, many of the programs will actually pay the seniors' part B cost.

When you represent a district that isn't wealthy, let me assure the Members of both sides of the aisle that this is an important medical program and it does give them choices. Nobody is forced into the Medicare Advantage plans, but they join them because it saves them money, while offering quality health care.

Yes, we all want to fix the cuts to the doctors. Yes, we want to make sure that the DME program is revised, and revised well. But we all know that it has already been said the Senate won't accept it, the President has just issued a veto threat on it, and so my question is: Why are we here?

Obviously, July 1 is right around the corner, and to take this up at the last minute when the bill was only available at 10 o'clock this morning, I think is an insult. It's an insult to the people who like the Medicare Advantage program and it certainly is an insult to every Member of this Chamber, 278 pages of a bill that we really don't know everything that is in it because it's now a little after 11:30 in the morning. So obviously nobody has had the time to adequately review the bill.

Medicare Advantage is a good program that helps so many low-income seniors. People have to ask: Why does the Democrat Party want to do away with this program? Shame, shame, shame.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, I want to thank my friend, the chairman of the Subcommittee on Health, for yielding.

Mr. Speaker, like any other great and necessary journey, the journey to improve Medicare must start with a first step. Although we can and must do more, this bill is that first step.

I want to just mention the pulmonary rehabilitation benefit and the