Millender-McDonald	Regula	Spratt
Miller (CA)	Reyes	Stabenow
Miller (FL)	Riggs	Stark
Minge	Riley	Stearns
Mink	Rivers	Stenholm
Moakley	Rodriguez	Stokes
Mollohan	Roemer	Strickland
Moran (KS)	Rogan	Stump
Moran (VA)	Rogers	Stupak
Morella	Rohrabacher	Sununu
Murtha	Ros-Lehtinen	Talent
Myrick	Rothman	Tanner
Nadler	Roukema	Tauscher
Neal	Roybal-Allard	Tauzin
Nethercutt	Royce	Taylor (MS)
Neumann	Rush	Taylor (NC)
Ney	Ryun	Thomas
Northup	Sabo	Thompson
Norwood	Salmon	Thornberry
Nussle	Sanchez	Thune
Oberstar	Sanders	Thurman
Obey	Sandlin	Tiahrt
Olver	Sanford	Torres
Ortiz	Sawyer	Towns
Owens	Saxton	Traficant
Oxley	Scarborough	Turner
Packard	Schaefer, Dan	Upton
Pallone	Schaffer, Bob	Velazquez
Pappas	Schumer	Vento
Parker	Scott	Visclosky
Pascrell	Sensenbrenner	Walsh
Pastor	Serrano	Wamp
Paxon	Sessions	Waters
Payne	Shadegg	Watkins
Pease	Shaw	Watt (NC)
Pelosi	Shays	Watts (OK)
Peterson (MN)	Shimkus	Waxman
Peterson (PA)	Shuster	Weldon (FL)
Petri	Sisisky	Weldon (PA)
Pickering	Skaggs	Weller
Pickett	Skeen	Wexler
Pitts	Skelton	Weygand
Pombo	Slaughter	White
Pomeroy	Smith (MI)	Whitfield
Porter	Smith (NJ)	Wicker
Portman	Smith (OR)	Wilson
Price (NC)	Smith (TX)	Wise
Quinn	Smith, Adam	Wolf
Radanovich	Smith, Linda	Woolsey
Rahall	Snowbarger	Wynn
Ramstad	Snyder	Yates
Rangel	Solomon	Young (AK)
Redmond	Souder	Young (FL)
	Spence	

NAYS—1

Paul

NOT VOTING—11

	John	Poshard
Berman	Johnson (WI)	Pryce (OH)
DeFazio	Kennelly	Sherman
Doggett	Lampson	Tierney

□ 1205

So (two-thirds having voted in favor thereof) the rules were suspended and the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

CORRECTING ENROLLMENT OF H.R. 3150, BANKRUPTCY REFORM ACT OF 1998

Mr. GEKAS. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the concurrent resolution (H.Con.Res. 346) to correct the enrollment of the bill H.R. 3150, and ask for its immediate consideration in the House.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore (Mr. LAHOOD). Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 346

Resolved by the House of Representatives (the Senate concurring), That, in the enrollment of the bill (H. R. 3150), to amend title 11 of the United States Code, and for other purposes, the Clerk of the House of Representatives shall make the following correction:

In section 1014 of the bill, strike ''Act'' each place it appears and insert ''title''.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to the provisions of clause 5 of rule I, the Chair announces that he will postpone further proceedings today on each motion to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote is objected to under clause 4 of rule XV.

Such rollcall votes, if postponed, will be taken later in the day.

ANNOUNCEMENT OF LEGISLATION TO BE CONSIDERED UNDER SUSPENSION OF THE RULES TODAY

Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 575, I announce the following suspensions to be considered today:

H.R. 4353; H.Res. 212; S. 1298; H.R. 4516; S. 191; S. 2235; and S. 2193.

S. 191—A bill to throttle criminal use of guns

S. 2235—A bill to amend part Q of the Omnibus Crime Control and Safe Streets Act of 1968 to encourage the use of school resource officers

S. 2193—Trademark Law Treaty Implementation Act

H.R. 4353—International Anti-Bribery and Fair Competition Act of 1998

H. Res. 212—recognizing suicide as a national problem

S. 1298—A bill to designate a Federal building located in Florence, Alabama, as the ''Justice John McKinley Federal Building''

H.R. 4516—A bill to designate the United States Postal Service building located at 11550 Livingston Road, in Oxon Hill, Maryland, as the ''Jacob Joseph Chestnut Post Office Building''

MEDICARE HOME HEALTH AND VETERANS HEALTH CARE IMPROVEMENT ACT OF 1998

Mr. THOMAS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4567) to amend title XVIII of the Social Security Act to make revisions in the per beneficiary and per visit payment limits on payment for health services under the Medicare Program, as amended.

The Clerk read as follows:

H.R. 4567

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Home Health and Veterans Health Care Improvement Act of 1998''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE HOME HEALTH CARE INTERIM PAYMENT SYSTEM REFINEMENT

SEC. 101. INCREASE IN PER BENEFICIARY LIMITS AND PER VISIT PAYMENT LIMITS FOR PAYMENT FOR HOME HEALTH SERVICES.

(a) INCREASE IN PER BENEFICIARY LIMITS.—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended—

(1) in the first sentence of clause (v), by inserting ''subject to clause (viii)(I),'' before ''the Secretary'';

(2) in clause (vi)(I), by inserting ''subject to clauses (viii)(II) and (viii)(III)'' after ''fiscal year 1994''; and

(3) by adding at the end the following new clause:

''(viii)(I) In the case of a provider with a 12-month cost reporting period ending in fiscal year 1994, if the limit imposed under clause (v) (determined without regard to this subclause) for a cost reporting period beginning during or after fiscal year 1999 is less than the median described in clause (vi)(I) (but determined as if any reference in clause (v) to '98 percent' were a reference to '100 percent'), the limit otherwise imposed under clause (v) for such provider and period shall be increased by ½ of such difference.

''(II) Subject to subclause (IV), for new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, but for which the first cost reporting period begins before fiscal year 1999, for cost reporting periods beginning during or after fiscal year 1999, the per beneficiary limitation described in clause (vi)(I) shall be equal to 50 percent of the median described in such clause plus 50 percent of the sum of 75 percent of such median and 25 percent of 98 percent of the standardized regional average of such costs for the agency's census division, described in clause (v)(I). However, in no case shall the limitation under this subclause be less than the median described in clause (vi)(I) (determined as if any reference in clause (v) to '98 percent' were a reference to '100 percent').

''(III) Subject to subclause (IV), in the case of a new home health agency for which the first cost reporting period begins during or after fiscal year 1999, the limitation applied under clause (vi)(I) (but only with respect to such provider) shall be equal to 75 percent of the median described in clause (vi)(I).

''(IV) In the case of a new provider or a provider without a 12-month cost reporting period ending in fiscal year 1994, subclause (II) shall apply, instead of subclause (III), to a home health agency which filed an application for home health agency provider status under this title before September 15, 1998, or which was approved as a branch of its parent agency before such date and becomes a subunit of the parent agency or a separate agency on or after such date.

''(V) Each of the amounts specified in subclauses (I) through (III) are such amounts as adjusted under clause (iii) to reflect variations in wages among different areas.''.

(b) REVISION OF PER VISIT LIMITS.—Section 1861(v)(1)(L)(i) of such Act (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (III), by striking ''or'';

(2) in subclause (IV)—

(A) by inserting ''and before October 1, 1998,'' after ''October 1, 1997,''; and

(B) by striking the period at the end and inserting '', or''; and

(3) by adding at the end the following new subclause:

''(V) October 1, 1998, 108 percent of such median.''.

(c) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839 of such Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(3), by inserting ''(except as provided in subsection (g))'' after ''year that''; and

(2) by adding at the end the following new subsection:

''(g) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to the application of section 1861(v)(1)(L)(viii) or to the establishment under section 1861(v)(1)(L)(i)(V) of a per visit limit at 108 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this title is not being made under section 1895 (relating to prospective payment for home health services).''.

(d) REPORTS ON SUMMARY OF RESEARCH CONDUCTED BY THE SECRETARY ON THE PROSPECTIVE PAYMENT SYSTEM.—By not later than January 1, 1999, the Secretary of Health and Human Services shall submit to Congress a report on the following matters:

(1) RESEARCH.—A description of any research paid for by the Secretary on the development of a prospective payment system for home health services furnished under the medicare care program under title XVIII of the Social Security Act, and a summary of the results of such research.

(2) SCHEDULE FOR IMPLEMENTATION OF SYSTEM.—The Secretary's schedule for the implementation of the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(3) ALTERNATIVE TO 15 PERCENT REDUCTION IN LIMITS.—The Secretary's recommendations for one or more alternative means to provide for savings equivalent to the savings estimated to be made by the mandatory 15 percent reduction in payment limits for such home health services for fiscal year 2000 under section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)), or, in the case the Secretary does not establish and implement such prospective payment system, under section 4603(e) of the Balanced Budget Act of 1997.

(e) MEDPAC REPORTS.—

(1) REVIEW OF SECRETARY'S REPORT.—Not later than 60 days after the date the Secretary of Health and Human Services submits to Congress the report under subsection (d), the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6)) shall submit to Congress a report describing the Commission's analysis of the Secretary's report, and shall include the Commission's recommendations with respect to the matters contained in such report.

(2) ANNUAL REPORT.—The Commission shall include in its annual report to Congress for June 1999 an analysis of whether changes in law made by the Balanced Budget Act of 1997, as modified by the amendments made by this section, with respect to payments for home health services furnished under the medicare program under title XVIII of the Social Security Act impede access to such services by individuals entitled to benefits under such program.

(f) GAO AUDIT OF RESEARCH EXPENDITURES.—The Comptroller General of the United States shall conduct an audit of sums obligated or expended by the Health Care Financing Administration for the research described in subsection (d)(1), and of the data, reports, proposals, or other information provided by such research.

(g) PROMPT IMPLEMENTATION.—The Secretary of Health and Human Services shall promptly issue (without regard to chapter 8 of title 5, United States Code) such regulations or program memoranda as may be necessary to effect the amendments made by this section for cost reporting periods beginning on or after October 1, 1998. In effecting the amendments made by subsection (a) for cost reporting periods beginning in fiscal year 1999, the ''median'' referred to in section 1861(v)(1)(L)(vi)(I) of the Social Security Act for such periods shall be the national standardized per beneficiary limitation specified in Table 3C published in the Federal Register on August 11, 1998, (63 FR 42926) and the ''standardized regional average of such costs'' referred to in section 1861(v)(1)(L)(v)(I) of such Act for a census division shall be the sum of the labor and nonlabor components of the standardized per-beneficiary limitation for that census division specified in Table 3B published in the Federal Register on that date (63 FR 42926) (or in Table 3D as so published with respect to Puerto Rico and Guam).

TITLE II—VETERANS MEDICARE ACCESS IMPROVEMENT

SEC. 201. IMPROVEMENT IN VETERANS' ACCESS TO SERVICES.

(a) IN GENERAL.—Title XVIII of the Social Security Act, as amended by sections 4603, 4801, and 4015(a) of the Balanced Budget Act of 1997, is amended by adding at the end the following:

''IMPROVING VETERANS' ACCESS TO SERVICES

''SEC. 1897. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary of Health and Human Services and the Secretary of Veterans Affairs acting jointly.

''(2) PROGRAM.—The term 'program' means the program established under this section with respect to category A medicare-eligible veterans.

''(3) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section with respect to category C medicare-eligible veterans.

''(4) MEDICARE-ELIGIBLE VETERANS.—

''(A) CATEGORY A MEDICARE-ELIGIBLE VETERAN.—The term 'category A medicare-eligible veteran' means an individual—

''(i) who is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in paragraph (1) or (2) of section 1710(a) of title 38, United States Code;

''(ii) who is entitled to hospital insurance benefits under part A of the medicare program and is enrolled in the supplementary medical insurance program under part B of the medicare program; and

''(iii) for whom the medical center of the Department of Veterans Affairs that is closest to the individual's place of residence is geographically remote or inaccessible from such place.

''(B) CATEGORY C MEDICARE-ELIGIBLE VETERAN.—The term 'category C medicare-eligible veteran' means an individual who—

''(i) is a veteran (as defined in section 101(2) of title 38, United States Code) and is described in section 1710(a)(3) of title 38, United States Code; and

''(ii) is entitled to hospital insurance benefits under part A of the medicare program and is enrolled in the supplementary medical insurance program under part B of the medicare program.

''(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

''(6) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) PROGRAM AND DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish—

''(i) a program (under an agreement entered into by the administering Secretaries) under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to category A medicare-eligible veterans; and

''(ii) a demonstration project (under such an agreement) under which the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs, from the trust funds, for medicare health care services furnished to category C medicare-eligible veterans.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the program and the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the program and demonstration project, including any cost sharing requirements;

''(iii) a description of the process for enrolling veterans for participation in the program, which process may, to the extent practicable, be administered in the same or similar manner to the registration process established to implement section 1705 of title 38, United States Code;

''(iv) a description of how the program and the demonstration project will satisfy the requirements under this title;

''(v) a description of the sites selected under paragraph (2);

''(vi) a description of how reimbursement requirements under subsection (g) and maintenance of effort requirements under subsection (h) will be implemented in the program and in the demonstration project;

''(vii) a statement that all data of the Department of Veterans Affairs and of the Department of Health and Human Services that the administering Secretaries determine is necessary to conduct independent estimates

and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the program and the demonstration project shall be available to the administering Secretaries;

''(viii) a description of any requirement that the Secretary of Health and Human Services waives pursuant to subsection (d);

''(ix) a requirement that the Secretary of Veterans Affairs undertake and maintain outreach and marketing activities, consistent with capacity limits under the program, for category A medicare-eligible veterans;

''(x) a description of how the administering Secretaries shall conduct the data matching program under subparagraph (F), including the frequency of updates to the comparisons performed under subparagraph (F)(ii); and

''(xi) a statement by the Secretary of Veterans Affairs that the type or amount of health care services furnished under chapter 17 of title 38, United States Code, to veterans who are entitled to benefits under part A or enrolled under part B, or both, shall not be reduced by reason of the program or project.

''(C) COST-SHARING UNDER DEMONSTRATION PROJECT.—Notwithstanding any provision of title 38, United States Code, in order—

''(i) to maintain and broaden access to services,

''(ii) to encourage appropriate use of services, and

''(iii) to control costs,

the Secretary of Veterans Affairs may establish enrollment fees and copayment requirements under the demonstration project under this section consistent with subsection (d)(1). Such fees and requirements may vary based on income.

''(D) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under the program and demonstration project to medicare-eligible veterans enrolled in the program or project. Those benefits shall include at least all medicare health care services covered under this title.

''(E) ESTABLISHMENT OF SERVICE NETWORKS.—

''(i) USE OF VA OUTPATIENT CLINICS.—The Secretary of Veterans Affairs, to the extent practicable, shall use outpatient clinics of the Department of Veterans Affairs in providing services under the program.

''(ii) AUTHORITY TO CONTRACT FOR SERVICES.—The Secretary of Veterans Affairs may enter into contracts and arrangements with entities (such as private practitioners, providers of services, preferred provider organizations, and health care plans) for the provision of services for which the Secretary of Health and Human Services is responsible under the program or project under this section and shall take into account the existence of qualified practitioners and providers in the areas in which the program or project is being conducted. Under such contracts and arrangements, such Secretary of Health and Human Services may require the entities to furnish such information as such Secretary may require to carry out this section.

''(F) DATA MATCH.—

''(i) ESTABLISHMENT OF DATA MATCHING PROGRAM.—The administering Secretaries shall establish a data matching program under which there is an exchange of information of the Department of Veterans Affairs and of the Department of Health and Human Services as is necessary to identify veterans who are entitled to benefits under part A or enrolled under part B, or both, in order to carry out this section. The provisions of section 552a of title 5, United States Code, shall apply with respect to such matching program only to the extent the administering Secretaries find it feasible and appropriate in carrying out this section in a timely and efficient manner.

''(ii) PERFORMANCE OF DATA MATCH.—The administering Secretaries, using the data matching program established under clause (i), shall perform a comparison in order to identify veterans who are entitled to benefits under part A or enrolled under part B, or both. To the extent such Secretaries deem appropriate to carry out this section, the comparison and identification may distinguish among such veterans by category of veterans, by entitlement to benefits under this title, or by other characteristics.

''(iii) DEADLINE FOR FIRST DATA MATCH.—The administering Secretaries shall first perform a comparison under clause (ii) by not later than October 31, 1998.

''(iv) CERTIFICATION BY INSPECTOR GENERAL.—

''(I) IN GENERAL.—The administering Secretaries may not conduct the program unless the Inspector General of the Department of Health and Human Services certifies to Congress that the administering Secretaries have established the data matching program under clause (i) and have performed a comparison under clause (ii).

''(II) DEADLINE FOR CERTIFICATION.—Not later than December 15, 1998, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the certification under subclause (I) or the denial of such certification.

''(2) NUMBER OF SITES.—The program and demonstration project shall be conducted in geographic service areas of the Department of Veterans Affairs, designated jointly by the administering Secretaries after review of all such areas, as follows:

''(A) PROGRAM SITES.—

''(i) IN GENERAL.—Except as provided in clause (ii), the program shall be conducted in not more than 3 such areas with respect to category A medicare-eligible veterans.

''(ii) ADDITIONAL PROGRAM SITES.—Subject to the certification required under subsection (h)(1)(B)(iii), for a year beginning on or after January 1, 2003, the program shall be conducted in such areas as are designated jointly by the administering Secretaries after review of all such areas.

''(B) PROJECT SITES.—

''(i) IN GENERAL.—The demonstration project shall be conducted in not more than 3 such areas with respect to category C medicare-eligible veterans.

''(ii) MANDATORY SITE.—At least one of the areas designated under clause (i) shall encompass the catchment area of a military medical facility which was closed pursuant to either the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101–510; 10 U.S.C. 2687 note) or title II of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526; 10 U.S.C. 2687 note).

''(3) RESTRICTION.—Funds from the program or demonstration project shall not be used for—

''(A) the construction of any treatment facility of the Department of Veterans Affairs; or

''(B) the renovation, expansion, or other construction at such a facility.

''(4) DURATION.—The administering Secretaries shall conduct and implement the program and the demonstration project as follows:

''(A) PROGRAM.—

''(i) IN GENERAL.—The program shall begin on January 1, 2000, in the sites designated under paragraph (2)(A)(i) and, subject to subsection (h)(1)(B)(iii)(II), for a year beginning on or after January 1, 2003, the program may be conducted in such additional sites designated under paragraph (2)(A)(ii).

''(ii) LIMITATION ON NUMBER OF VETERANS COVERED UNDER CERTAIN CIRCUMSTANCES.—If for a year beginning on or after January 1, 2003, the program is conducted only in the sites designated under paragraph (2)(A)(i), medicare health care services may not be provided under the program to a number of category-A medicare-eligible veterans that exceeds the aggregate number of such veterans covered under the program as of December 31, 2002.

''(B) PROJECT.—The demonstration project shall begin on January 1, 1999, and end on December 31, 2001.

''(C) IMPLEMENTATION.—The administering Secretaries may implement the program and demonstration project through the publication of regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(5) REPORTS.—

''(A) PROGRAM.—By not later than September 1, 1999, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) with respect to the program to Congress.

''(B) PROJECT.—By not later than November 1, 1998, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) with respect to the project to Congress.

''(6) REPORT ON MAINTENANCE OF LEVEL OF HEALTH CARE SERVICES.—

''(A) IN GENERAL.—The Secretary of Veterans Affairs may not implement the program at a site designated under paragraph (2)(A) unless, by not later than 90 days before the date of the implementation, the Secretary of Veterans Affairs submits to Congress and to the Comptroller General of the United States a report that contains the information described in subparagraph (B). The Secretary of Veterans Affairs shall periodically update the report under this paragraph as appropriate.

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is a description of the operation of the program at the site and of the steps to be taken by the Secretary of Veterans Affairs to prevent the reduction of the type or amount of health care services furnished under chapter 17 of title 38, United States Code, to veterans who are entitled to benefits under part A or enrolled under part B, or both, within the geographic service area of the Department of Veterans Affairs in which the site is located by reason of the program or project.

''(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Veterans Affairs under the program or demonstration project shall be credited to the applicable Department of Veterans Affairs medical care appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Veterans Affairs during the fiscal year during which the payment is received.

''(d) APPLICATION OF CERTAIN MEDICARE REQUIREMENTS.—

''(1) AUTHORITY.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), the program and the demonstration project shall meet all requirements of Medicare+Choice plans under part C and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

''(B) WAIVER.—Except as provided in paragraph (2), the Secretary of Health and Human Services is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative

ways of meeting such a requirement, but only if such waiver or approval—

''(i) reflects the unique status of the Department of Veterans Affairs as an agency of the Federal Government; and

''(ii) is necessary to carry out the program or demonstration project.

''(2) BENEFICIARY PROTECTIONS AND OTHER MATTERS.—The program and the demonstration project shall comply with the requirements of part C of this title that relate to beneficiary protections and other matters, including such requirements relating to the following areas, to the extent not inconsistent with subsection (b)(1)(B)(iii):

''(A) Enrollment and disenrollment.

''(B) Nondiscrimination.

''(C) Information provided to beneficiaries.

''(D) Cost-sharing limitations.

''(E) Appeal and grievance procedures.

''(F) Provider participation.

''(G) Access to services.

''(H) Quality assurance and external review.

''(I) Advance directives.

''(J) Other areas of beneficiary protections that the administering Secretaries determine are applicable to such program or project.

''(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the program and demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(f) VOLUNTARY PARTICIPATION.—Participation of a category A medicare-eligible veteran in the program or category C medicare-eligible veteran in the demonstration project shall be voluntary.

''(g) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services shall reimburse the Secretary of Veterans Affairs for services provided under the program or demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part C of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary of Health and Human Services shall establish rules for computing equivalent or comparable payment amounts.

''(2) EXCLUSION OF CERTAIN AMOUNTS.—In computing the amount of payment under paragraph (1), the following shall be excluded:

''(A) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

''(B) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(3) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(A) on a periodic basis consistent with the periodicity of payments under this title; and

''(B) in appropriate part, as determined by the Secretary of Health and Human Services, from the trust funds.

''(4) CAP ON REIMBURSEMENT AMOUNTS.—The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) is as follows:

''(A) PROGRAM.—With respect to category A medicare-eligible veterans, such aggregate amount shall not exceed—

''(i) for 2000, a total of $50,000,000;

''(ii) for 2001, a total of $75,000,000; and

''(iii) subject to subparagraph (B), for 2002 and each succeeding year, a total of $100,000,000.

''(B) EXPANSION OF PROGRAM.—If for a year beginning on or after January 1, 2003, the program is conducted in sites designated under subsection (b)(2)(A)(ii), the limitation under subparagraph (A)(iii) shall not apply to the program for such a year.

''(C) PROJECT.—With respect to category C medicare-eligible veterans, such aggregate amount shall not exceed a total of $50,000,000 for each of calendar years 1999 through 2001.

''(h) MAINTENANCE OF EFFORT.—

''(1) MONITORING EFFECT OF PROGRAM AND DEMONSTRATION PROJECT ON COSTS TO MEDICARE PROGRAM.—

''(A) IN GENERAL.—The administering Secretaries, in consultation with the Comptroller General of the United States, shall closely monitor the expenditures made under this title for category A and C medicare-eligible veterans compared to the expenditures that would have been made for such veterans if the program and demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require the Department of Veterans Affairs to maintain overall the level of effort for services covered under this title to such categories of veterans by reference to a base year as determined by the administering Secretaries.

''(B) DETERMINATION OF MEASURE OF COSTS OF MEDICARE HEALTH CARE SERVICES.—

''(i) IMPROVEMENT OF INFORMATION MANAGEMENT SYSTEM.—Not later than October 1, 2001, the Secretary of Veterans Affairs shall improve its information management system such that, for a year beginning on or after January 1, 2002, the Secretary of Veterans Affairs is able to identify costs incurred by the Department of Veterans Affairs in providing medicare health care services to medicare-eligible veterans for purposes of meeting the requirements with respect to maintenance of effort under an agreement under subsection (b)(1)(A).

''(ii) IDENTIFICATION OF MEDICARE HEALTH CARE SERVICES.—The Secretary of Health and Human Services shall provide such assistance as is necessary for the Secretary of Veterans Affairs to determine which health care services furnished by the Secretary of Veterans Affairs qualify as medicare health care services.

''(iii) CERTIFICATION BY HHS INSPECTOR GENERAL.—

''(I) REQUEST FOR CERTIFICATION.—The Secretary of Veterans Affairs may request the Inspector General of the Department of Health and Human Services to make a certification to Congress that the Secretary of Veterans Affairs has improved its management system under clause (i) such that the Secretary of Veterans Affairs is able to identify the costs described in such clause in a reasonably reliable and accurate manner.

''(II) REQUIREMENT FOR EXPANSION OF PROGRAM.—The program may be conducted in the additional sites under paragraph (2)(A)(ii) and cover such additional category A medicare eligible veterans in such additional sites only if the Inspector General of the Department of Health and Human Services has made the certification described in subclause (I).

''(III) DEADLINE FOR CERTIFICATION.—Not later than the date that is the earlier of the date that is 60 days after the Secretary of Veterans Affairs requests a certification under subclause (I) or June 1, 2002, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the certification under subclause (I) or the denial of such certification.

''(C) MAINTENANCE OF LEVEL OF EFFORT.—

''(i) REPORT BY SECRETARY OF VETERANS AFFAIRS ON BASIS FOR CALCULATION.—Not later than the date that is 60 days after the date on which the administering Secretaries enter into an agreement under subsection (b)(1)(A), the Secretary of Veterans Affairs shall submit a report to Congress and the Comptroller General of the United States explaining the methodology used and basis for calculating the level of effort of the Department of Veterans Affairs under the program and project.

''(ii) REPORT BY COMPTROLLER GENERAL.—Not later than the date that is 180 days after the date described in clause (i), the Comptroller General of the United States shall submit to Congress and the administering Secretaries a report setting forth the Comptroller General's findings, conclusion, and recommendations with respect to the report submitted by the Secretary of Veterans Affairs under clause (i).

''(iii) RESPONSE BY SECRETARY OF VETERANS AFFAIRS.—The Secretary of Veterans Affairs shall submit to Congress not later than 60 days after the date described in clause (ii) a report setting forth such Secretary's response to the report submitted by the Comptroller General under clause (ii).

''(D) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the program and demonstration project is conducted, the Comptroller General of the United States shall submit to the administering Secretaries and to Congress a report on the extent, if any, to which the costs of the Secretary of Health and Human Services under the medicare program under this title increased during the preceding fiscal year as a result of the program or demonstration project.

''(2) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(A) IN GENERAL.—If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the program or demonstration project, the administering Secretaries shall take such steps as may be needed—

''(i) to recoup for the medicare program the amount of such increase in expenditures; and

''(ii) to prevent any such increase in the future.

''(B) STEPS.—Such steps—

''(i) under subparagraph (A)(i) shall include payment of the amount of such increased expenditures by the Secretary of Veterans Affairs from the current medical care appropriation for the Department of Veterans Affairs to the trust funds; and

''(ii) under subparagraph (A)(ii) shall include lowering the amount of payment under the program or project under subsection (g)(1), and may include, in the case of the demonstration project, suspending or terminating the project (in whole or in part).

''(i) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION BY GAO.—

''(A) IN GENERAL.—The Comptroller General of the United States shall conduct an evaluation of the program and an evaluation of the demonstration project, and shall submit annual reports on the program and demonstration project to the administering Secretaries and to Congress.

''(B) FIRST REPORT.—The first report for the program or demonstration project under subparagraph (A) shall be submitted not later than 12 months after the date on which the Secretary of Veterans Affairs first provides services under the program or project, respectively.

''(C) FINAL REPORT ON DEMONSTRATION PROJECT.—A final report shall be submitted with respect to the demonstration project not later than 3½ years after the date of the first report on the project under subparagraph (B).

''(D) CONTENTS.—The evaluation and reports under this paragraph for the program or demonstration project shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(i) Any savings or costs to the medicare program under this title resulting from the program or project.

''(ii) The cost to the Department of Veterans Affairs of providing care to category A medicare-eligible veterans under the program or to category C medicare-eligible veterans under the demonstration project, respectively.

''(iii) An analysis of how such program or project affects the overall accessibility of medical care through the Department of Veterans Affairs, and a description of the unintended effects (if any) upon the patient enrollment system under section 1705 of title 38, United States Code.

''(iv) Compliance by the Department of Veterans Affairs with the requirements under this title.

''(v) The number of category A medicare-eligible veterans or category C medicare-eligible veterans, respectively, opting to participate in the program or project instead of receiving health benefits through another health insurance plan (including benefits under this title).

''(vi) A list of the health insurance plans and programs that were the primary payers for medicare-eligible veterans during the year prior to their participation in the program or project, respectively, and the distribution of their previous enrollment in such plans and programs.

''(vii) Any impact of the program or project, respectively, on private health care providers and beneficiaries under this title that are not enrolled in the program or project.

''(viii) An assessment of the access to care and quality of care for medicare-eligible veterans under the program or project, respectively.

''(ix) An analysis of whether, and in what manner, easier access to medical centers of the Department of Veterans Affairs affects the number of category A medicare-eligible veterans or C medicare-eligible veterans, respectively, receiving medicare health care services.

''(x) Any impact of the program or project, respectively, on the access to care for category A medicare-eligible veterans or C medicare-eligible veterans, respectively, who did not enroll in the program or project and for other individuals entitled to benefits under this title.

''(xi) A description of the difficulties (if any) experienced by the Department of Veterans Affairs in managing the program or project, respectively.

''(xii) Any additional elements specified in the agreement entered into under subsection (b).

''(xiii) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the program or project, respectively.

''(2) REPORTS BY SECRETARIES ON PROGRAM AND DEMONSTRATION PROJECT WITH RESPECT TO MEDICARE-ELIGIBLE VETERANS.—

''(A) DEMONSTRATION PROJECT.—Not later than 6 months after the date of the submission of the final report by the Comptroller General of the United States on the demonstration project under paragraph (1)(C), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(i) whether there is a cost to the health care program under this title in conducting the demonstration project;

''(ii) whether to extend the demonstration project or make the project permanent; and

''(iii) whether the terms and conditions of the project should otherwise be continued (or modified) with respect to medicare-eligible veterans.

''(B) PROGRAM.—Not later than 6 months after the date of the submission of the report by the Comptroller General of the United States on the third year of the operation of the program, the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(i) whether there is a cost to the health care program under this title in conducting the program under this section;

''(ii) whether to discontinue the program with respect to category A medicare-eligible veterans; and

''(iii) whether the terms and conditions of the program should otherwise be continued (or modified) with respect to medicare-eligible veterans.

''(j) APPLICATION OF MEDIGAP PROTECTIONS TO DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph (2), the provisions of section 1882(s)(3) (other than clauses (i) through (iv) of subparagraph (B)) and 1882(s)(4) shall apply to enrollment (and termination of enrollment) in the demonstration project, in the same manner as they apply to enrollment (and termination of enrollment) with a Medicare+Choice organization in a Medicare+Choice plan.

''(2) In applying paragraph (1)—

''(A) any reference in clause (v) or (vi) of section 1882(s)(3)(B) to 12 months is deemed a reference to 36 months; and

''(B) the notification required under section 1882(s)(3)(D) shall be provided in a manner specified by the Secretary of Veterans Affairs.''.

(b) REPEAL OF PLAN REQUIREMENT.—Subsection (b) of section 4015 of the Balanced Budget Act of 1997 (relating to an implementation plan for Veterans subvention) is repealed.

(c) REPORT TO CONGRESS ON A METHOD TO INCLUDE THE COSTS OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN THE CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—The Secretary of Health and Human Services shall report to the Congress by not later than January 1, 2001, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs or the Department of Defense to medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation payment. Such report shall include on a county-by- county basis—

(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;

(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;

(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and

(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program.

TITLE III—AUTHORIZATION OF ADDITIONAL EXCEPTIONS TO IMPOSITION OF PENALTIES FOR CERTAIN INDUCEMENTS

SEC. 301. AUTHORIZATION OF ADDITIONAL EXCEPTIONS TO IMPOSITION OF PENALTIES FOR PROVIDING INDUCEMENTS TO BENEFICIARIES.

(a) IN GENERAL.—Subparagraph (B) of section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended to read as follows:

''(B) any permissible practice described in any subparagraph of section 1128B(b)(3) or in regulations issued by the Secretary;''.

(b) EXTENSION OF ADVISORY OPINION AUTHORITY.—Section 1128D(b)(2)(A) of such Act (42 U.S.C. 1320a–7d(b)(2)(A)) is amended by inserting ''or section 1128A(i)(6)'' after ''1128B(b)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(d) INTERIM FINAL RULEMAKING AUTHORITY.—The Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment, in order to implement the amendments made by this section in a timely manner.

TITLE IV—EXPANSION OF MEMBERSHIP OF THE MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 401. EXPANSION OF MEMBERSHIP OF MEDPAC TO 17.

(a) IN GENERAL.—Section 1805(c)(1) of the Social Security Act (42 U.S.C. 1395b–6(c)(1)), as added by section 4022 of the Balanced Budget Act of 1997, is amended by striking ''15'' and inserting ''17''.

(b) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(1) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission (under section 1805(c)(3) of such Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the two additional members of the Commission provided for by the amendment under subsection (a) are as follows:

(A) One member shall be appointed for one year.

(B) One member shall be appointed for two years.

(2) COMMENCEMENT OF TERMS.—Such terms shall begin on May 1, 1999.

TITLE V—REVENUE OFFSET

SEC. 501. REVENUE OFFSET.

(a) IN GENERAL.—Subparagraph (B) of section 408A(c)(3) of the Internal Revenue Code of 1986 is amended by striking ''relates'' and all that follows and inserting ''relates, the taxpayer's adjusted gross income exceeds $145,000 ($290,000 in the case of a joint return).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to distributions after December 31, 1998.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. THOMAS) and the gentleman from California (Mr. STARK) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that 8 of those 20 minutes in the affirmative be controlled by the gentleman from Florida (Mr. BILIRAKIS), chairman of the Subcommittee on Health of the Committee on Commerce.

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

There was no objection.

GENERAL LEAVE

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 4567.

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

There was no objection.

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

Mr. Speaker, this bill, H.R. 4567, is one that is needed for a number of reasons. Most people will probably focus on what they consider to be the major provision, and that is a modification in the home health care payment structure.

In the Balanced Budget Act of 1997, after extensive negotiations with the administration, we were able to get the administration to change their 100 percent structure to a blended arrangement which we thought would at least modify the perniciousness of the administration's approach. We could not get them to go farther. That position became the interim payment structure that we are operating under now. Once we were able to examine what the administration really wanted, we discovered that it was lacking in a number of provisions in assisting on a broad base home health care agencies previously established, newly established and between States.

Not only was it not adequate in its interim payment structure form, but we were told in August by the Health Care Financing Administration that, because of their computers' difficulties with the year 2000 problem, they would not be able to honor the date that they said the prospective payment system replacing the interim payment system would go into effect. What ensued was a series of negotiations among all of those parties affected, and a bill was passed through the Committee on Ways and Means, modified by the Committee on Commerce's concerns and with the administration as a full partner to make sure that anything that we proposed could actually be carried out by the administration because of the year 2000 computer problems.

We have in front of us, I believe, a solution in which there are no losers. One of the difficulties is that many of the proposals basically robbed Peter to pay Paul, revenue neutral. Even if they added money to the pot, it was clear that it was only perpetuating an unfair system. Although we perhaps add more money than I would have liked to have added to the overall pot to solve the problem, the most important provision is that it treats those who are most in need fairly, and that is essential, I think, if in these latter days we are able to move this legislation.

A second provision of this bill is a veterans' subvention program. The Department of Defense has a Medicare subvention demonstration program. We were anxious to involve the veterans. This is a perfected veterans' subvention program.

There are basically two categories of veterans. The category C are those who are relatively well off, vis-a-vis the category A veterans, and who do not have service-related disabilities. The primary focus is on the category A veterans. There is a real problem in this area. We believe that this provision is a worthwhile one. It is a demonstration for both of us, and the chairman of the Committee on Veterans' Affairs will speak to that very shortly.

There are two other minor provisions. One is to allow for the reinstitution of a long-standing practice in which those patients who are end-stage renal disease patients and unable to provide for insurance coverage are assisted in that insurance coverage. Through a technical failure in our fraud and abuse program, that technically would not be allowed. This creates an opportunity for the Inspector General at HHS to make sure there is a safe harbor to protect those individuals.

The last item is an expansion of the MedPAC board, which would provide for a broadening of the representational interests on that board, be they professional, general public or geographic, based upon who those additional members would be.

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

Mr. STARK. Mr. Speaker, I ask unanimous consent that 6 minutes of debate time be allocated to the gentleman from Pennsylvania (Mr. KLINK).

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

There was no objection.

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

Mr. Speaker, the bill that the gentleman from California (Mr. THOMAS) and the Republican leadership have crafted does some good things: The subvention. There are some issues dealing with Medicare payments to people with end-stage renal disease that are helpful. There is an attempt to fix or assist the problems that are being caused in the home health delivery system by the administration's inability to get their act together.

Having said that, they have snatched victory from the jaws of defeat and pounded it to death. The bill is now a tax loophole and a stealth pay raise for Members of Congress and it has combined a series of measures and almost assured its defeat in the Senate because it violates the Senate rules and costs $10 billion over the next 10 years. Admittedly we only work in a 5-year time frame. They would raise a point of order in the Senate and need 60 votes and it is unlikely that it would pass there.

□ 1215

It extends a tax break to the very wealthy and now includes Members of Congress. Previously we were unable, as Members of Congress, to take advantage of Roth IRAs, and we now will be able to so that we have, and I am sure people will soon discover, we are about to vote ourselves a pay raise. I vote for pay raises, but I like to do it up front so that my constituents know that. I think it is too bad that we are doing it. It violates the budget, the IRA tax breaks have been dropped in conference or must be dropped or the bill is doomed.

We had suggested in the Committee on Ways and Means the postponement and reduction of medical savings accounts for seniors, and, interestingly enough, there are not any. There is no company offering medical savings accounts to seniors, and we could have saved a billion dollars and postponed the 15 percent tax cut which the home health industry is staring in the face next year. That was defeated by the Republicans in the Committee on Ways and Means, and I hope that if this bill goes to conference we could reestablish that. It hurts no one, there is no insurance company selling it, no seniors can buy it, we have already lost 300 million in savings which has evaporated. Through the inactivity or ignorance of the Republican bill we are going to let more of that savings disappear which could be used to help home health agencies who need it.

Again, this bill gives up, loses, $10.7 billion, does precious little except for the most egregious home health providers and mostly in southern States who have taken most advantage of this payment, and we could have done a better job, Mr. Speaker, we could have not dipped into the surplus so egregiously, and I hope that when this bill comes to conference, if in fact it ever does, that we can correct it at that point.

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

Mr. THOMAS. Mr. Speaker, I yield myself 30 seconds.

Notwithstanding the gentleman's description of the bill, the paid-for provision which increases the individual retirement accounts on ROTH IRAs from 100,000 to 145,000 does comport with the budget rules on the House side, and in looking for areas to pay for a change in Medicare and related medical costs, we thought it most prudent not to dip into Medicare or other health care provisions to rob Peter to pay Paul, and it seems to me that this is a particularly appropriate way within the House budget rules.

Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. STUMP), the distinguished Chairman of the Committee on Veterans' Affairs.

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

I rise in strong support of this measure and am pleased to be an original cosponsor. This legislation would realize one of the top priorities of our national veterans organizations, enabling

Medicare-eligible veterans for the first time to get Medicare coverage through the VA. This legislation would expand veterans' options and their access to care while still offering the promise of reducing Medicare costs.

While the Committee on Veterans' Affairs took the lead in reporting out this legislation, I am indeed indebted to my friend, the gentleman from California (Mr. THOMAS), the primary architect of the broader VA Medicare provisions being taken up today. BILL THOMAS' highly acclaimed expertise on the Medicare program and his willingness to become knowledgeable on VA health care with key to moving this legislation, and I would also like to thank the gentleman from Florida (Mr. BILIRAKIS) who is an original cosponsor and has been a tireless champion for veterans.

Veterans' legislation is truly nonpartisan, and I want to salute our colleagues on the other side of the aisle on the Committee on Ways and Means, the Committee on Commerce and the Committee on Veterans Affairs who helped advance this legislation.

Mr. Speaker, this is a good bill for veterans, and I urge the Members to adopt it.

Mr. BILBRAY. Mr. Speaker, I yield myself such time as I might consume.

Mr. Speaker, our bill is the result of hard work between the Committee on Commerce and Committee on Ways and Means. Many of us have heard from constituents, principally veterans and senior citizens who are or may be effected by current health policy which we address and improve in the bill before us today.

H.R. 4567 proves, I think, that Members of Congress do listen to the concerns of their constituents and, when appropriate, work to find viable solutions. Several issues are addressed in this legislation.

Long ago our Nation made a commitment to care for the brave men and women who fought the battles to keep America free, and these are our Nation's veterans. As a veteran myself and a representative of a congressional district with a large veterans population, I am pleased that we have incorporated a Veterans Medicare Access Improvement Act into H.R. 4567. The Veterans Medicare Access Improvement Act will permit the Medicare program to reimburse the VA for care given to Medicare eligible veterans. The bill provides new health care options to veterans who have previously been shut out of the VA health care system, and it allows the VA to reach out to thousands of underserved veterans.

The home health issue is also addressed. Currently one out of every ten Medicare beneficiaries receives close to 80 home health visits per year. BBA 97 sought to address the over utilization of home health services by directing HCFA to create a prospective payment system for the home health industry by October of 1999. Initially HCVA was told to implement an interim payment system which would allow home health agencies to make the transition to the new prospective payment system. HCFA recently informed Congress, unfortunately, that it could not make the October 1, 1999, deadline, thus forcing home health agencies to live with the reimbursement policy which many believe is unfair and will cause numerous facilities to shut down. Through this bill we make the payments to both old and new home health facilities more equitable, thus creating a more even playing field for home health agencies across the country, and most important, we restore assurance to Medicare beneficiaries that they will continue to have home health care services.

Our home health reforms build on three simple and yet crucial principles: equity, resolving the arbitrary differences inadvertently created by BBA 97; transitional sensitivity helping home health agencies not only survive the interim payment system, but also place them squarely on the track for the impending prospective payment system and implementability guaranteeing that HCFA can immediately put into effect the reforms we authorize.

In closing, Mr. Speaker, I urge my colleagues to support the Medicare and Veterans Health Improvement Act.

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

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank my friend for yielding me this time, and let me thank also the Chairman of our Subcommittee on Health for bringing forward this legislation. This is important legislation to deal with the home health care services in our community.

Mr. Speaker, last year we made a mistake, and now we need to correct it. We are moving towards implementing a prospective payment system for home health care providers, and that will reward efficiency and cost effective programs. We had anticipated that that new system would be in effect on October 1, 1999. We are not going to make that date. HCFA has made that clear. In the interim we have developed an interim payment system, and we tried to hold each provider somewhat harmless. But what we did was penalize cost-efficient programs by tying the interim payment system to historical costs. A program that already has a low number of per-patient visits and has got its cost down is discriminated against. We need to take steps to correct it. The legislation before us will correct that circumstance by allowing those programs that are below the national average cost to get a bonus payment by mixing the costs with their historical cost and what the average cost is in the Nation.

That makes sense. That will help many health care providers in our Nation.

In my own State of Maryland, where our costs are well below the national average because our number of patient visits on home health care services is below the national average we would be adversely impacted unless this legislation is enacted. We have far fewer number of providers per our population than most States, and yet if we do not enact legislation, Maryland, a cost effective state that is doing the right thing, we are in jeopardy, we are told, of losing 13 of our providers in our State that will not be able to make it unless we provide some relief.

So this legislation makes sense. We should take steps in order to deal with the interim situation until we can implement the perspective payment system, and I thank the gentleman for yielding me this time.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON) a member of the Committee on Ways and Means without whose full participation, ideas and creative approaches to solutions we would not be here with this bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman for those kind remarks and thank the gentleman from California (Mr. THOMAS), the gentleman from Florida (Mr. BILIRAKIS), the gentleman from Texas (Mr. ARCHER) and the gentleman from Florida (Mr. BLILEY) for their hard work to bring this bill to the floor. Indeed the need is urgent.

I would remind Members that when we passed the Balanced Budget Amendment we anticipated slowing growth in the cost of home health services by $16 billion because of the law we wrote. But equally important, because of the administrative changes HCFA made on its own or failed to make to comply with the budget document and because the work of the work of the Inspector General's office, there has been an interaction on this critical service sector that CBO estimates now will take 26 billion out of these services. That is 10 billion more than we anticipated. Believe me, this is a critical industry under terrible distress, and it is our job to fix it.

So I strongly support this bill that does bring much needed relief to specifically low cost, high quality home health providers nationwide, and I want to state for the record that some home health agencies in my State of Connecticut are not only low cost, but according to a government conducted audit they are also virtually free of fraud and abuse. We have legitimate concerns about fraud and abuse in the home health industry. But the Yankee spirit that has kept home health costs low in Connecticut has also kept home health spending honest and home health services high quality.

Ultimately the interim payment system we passed last year penalizes efficient home health providers that have served the Medicare program by keeping their costs down. These are the very providers that we need to preserve in the system if we expect to keep

Medicare spending affordable and Medicare operating well in the next century. This legislation will preserve our low cost providers, correct the problems of the past and enable us to establish a strong Medicare system that serves our seniors in the future.

Mr. Speaker, I want to thank Chairmen THOMAS, BILIRAKIS, ARCHER and BLILEY and their staff for their hard work on bringing this important bill to the floor today.

I support this bill because it brings much-needed relief to low-cost, high-quality home health providers nationwide. And I want to state for the record, that home health agencies in my home state of Connecticut are not only low-cost, but—according to a government-conducted audit—they are also virtually free of fraud and abuse. We have heard legitimate concerns about fraud and abuse nationwide in the home health industry, but the Yankee spirit that has kept home health costs low in Connecticut has also kept home health spending honest and home health services high quality.

Unfortunately, the interim payment system we passed last year penalizes efficient home health providers who have served the Medicare program by keeping their costs down. These are the very providers that we need to preserve in the system if we expect to keep Medicare operating in the next century. This legislation will preserve low-cost providers by increasing their rates during the transition to the new payment system.

The best solution for the long-term is to move home health care into a prospective payment system (PPS), where payments will based on the health needs of the patient and recognize those who need more intense services. The real tragedy of the current system is that we don't have the data necessary to build a system based on patient need. And the agency administering Medicare cannot accomplish this goal by the statutory date of October 1, 1999.

To prevent IPS, which is not adjusted for the severity of illness, from compromising the ability of important community providers to care for seniors and to ensure that the PPS will go into effect in a timely and accurate manner, this bill will reform IPS and require reports to Congress that will demonstrate progress on PPS development and account for all the resources used.

This bill also includes an important provision that will enable our veterans to seek Medicare-reimbursed services in veterans hospitals. This will strengthen our VA hospitals and open up accessible care for low income veterans.

I urge my colleagues to support this important bill and work to ensure that it passes before we adjourn.

Mr. KLINK. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, we are here today to fix some of the problems caused by the deep cuts in the Balanced Budget Amendment made in the Medicare home health care benefits. This is not a perfect bill. It is, first of all, not retroactive, it does not address the 15 percent cut scheduled for next year like the Democrat bill would have, and I really do not like the way it is paid for, but I support this bill today because I have heard from too many people in my district who are worried about the drastic impacts the interim payment system is having on the home health care providers and on the patients they serve.

I am going to support this bill because somewhere in this debate over how we should pay for home health care we are losing the focus on the seniors who need that home health care and who without it are going to end up back in the hospital or back in nursing homes. But for the life of me I do not understand why the costs of Medicare home health benefits vary so much from State to State and region to region; why, for example in my district, people who are treated by Nancy Dlusky in Greensburg, Pennsylvania, or Carol Rimer in Delmont, Pennsylvania, get on average only $2,300 a year while in other parts of the country for the same services people are being reimbursed 8, 10, 12 thousand dollars a year.

This is not a perfect bill, but it is a step in the right direction, and I hope that in conference we can perfect it even further.

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

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. LEVIN).

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

□ 1230

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

The IPS, Interim Payment System, has been grossly unfair, grossly unfair to low-cost, cost-effective providers in States, especially States like Michigan. This is a step in the right direction.

But I want to express two hopes. Number one, this is not retroactive. A lot of very good, healthy, once healthy, home health agencies have been terribly hurt. I think our system should protect the cost effective and not assist those that are cost ineffective. So I hope if this bill gets to conference that we can look at that issue.

Also, the chairman of the subcommittee and I have talked about the entire bill. I hope we can take another look in the way we pay for this. I do not think we should mortgage the future to correct the past or the present. So I rise in support of this bill. It is urgently needed.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Speaker, first of all, let me thank the gentleman from California (Mr. THOMAS) and the gentleman from Florida (Mr. BILIRAKIS) for addressing this issue.

There is no question, many things needed to be done to straighten out the problems in home health care. There are still problems with this bill. I am going to support this bill, and it is my hope that this will come through.

With the interim payment system, there is no recognition of the need for the chronically ill, dependent senior for home health. We need outlier protection for those firms who really take care of our seniors, who have proven that they will not dump a senior just because the money wears out.

Unfortunately, with HCFA and their administration of the Balanced Budget Act, not the amendment, but the act, the administration of that act has, in my State, penalized the best and helped the worst. This will go a long way towards changing that.

It, however, does not do anything with the 15 percent cut that is to go into effect October 1 of 1999, which has to be addressed if we are going to keep these firms viable and care for our seniors.

In closing, I have two people in my district that I would like to thank who have worked tirelessly, without ceasing, to try to solve some of these problems with great new ideas. Their names are Mark Lemmons and Steve Money. One is a former bank examiner, and the other is a former businessman. They are not home health care people, but they know costs, and they care for seniors. We have to make sure something happens on this before we leave this town.

Mr. KLINK. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I am pleased to see that we are at least moving forward in an attempt to do something to correct the home health crisis.

New Jersey's home health providers are among the most efficient in the Nation; and, in my view, it is unfair to penalize those agencies for their efficiency.

I also want to address this 15 percent cut. As we know, the Balanced Budget Act, as everyone who has been affected by this problem knows, mandates a 15 percent across-the-board reduction to the per beneficiary caps in fiscal year 2000 if the prospective payment system is not ready by that time. We already know that it will not be. I would like to have a provision postponing that cut included in this legislation.

Mr. Speaker, 2 days ago, the gentleman from Michigan (Mr. DINGELL) and a number of my Democratic colleagues in the House introduced a bill that would reach the goal by reducing the enrollment cap on Medical Savings Accounts demonstration projects in the short term.

Reducing the enrollment cap on MSAs, moreover, makes even more sense when we consider that nobody has signed up for an MSA yet. It is my understanding the other body was working on a proposal that would include this reduction, and I hope we are successful on getting that postponement included. I think that is very important.

Mr. THOMAS. Mr. Speaker, it is my privilege to yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH),

a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank the Speaker and my colleague from California for the time and having the privilege to serve on two of the three committees with jurisdiction, both the Committee on Ways and Means and the Committee on Veterans' Affairs.

I am pleased to rise with the dean of our Arizona delegation and the chairman of the Committee on Veterans' Affairs, the gentleman from Arizona (Mr. STUMP), in strong support of this legislation.

As has been chronicled by people from both sides of the aisle with disparate views of the role of government in health care, we all agree today, Mr. Speaker, that this is an idea whose time has come, not only for the challenges confronting home health care, challenges that in and of themselves tend to make HCFA truly a four-letter word, if not an acronym, in terms of the administration and practical applicability of ideas, but also for those Americans who have worn the uniform of our Armed Services and served with distinction both in wartime or in peacetime, especially in a place like the Sixth Congressional District of Arizona, a district in square mileage almost the size of the Commonwealth of Pennsylvania.

This is historic legislation because it would permit the VA to establish service networks to provide Medicare-reimbursed care to service-connected or financially needy Medicare-eligible veterans for whom VA medical centers are geographically remote or inaccessible. While we are working to establish these service centers for these veterans, this is another tool that can be utilized to give these veterans flexibility and access to health care in their senior years.

For these reasons and many more too numerous to mention, Mr. Speaker, I would ask all of my colleagues on both sides of the aisle to join in strong support of this legislation.

Mr. STARK. Mr. Speaker, I am honored to yield 1 minute to the gentleman from South Carolina (Mr. SPRATT), the distinguished ranking member of the Committee on the Budget.

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

Mr. SPRATT. Mr. Speaker, I have long supported VA subvention, and I want to fix the home health care payment formula as much as anybody on the floor, although I am not sure this bill does much for home health care in my State.

I am sure of this, it deals a body blow to the deficit. This bill adds $6.9 billion in new spending over the next 10 years, $6.9 billion. It cuts revenues, reduces tax revenues by $4.9 billion. So it takes a whack of nearly $12 billion out of the budget, out of the surplus over the next 12 years.

Ironically, that is because the Roth IRA provision put in here as a ''pay for'' does save money over the first 5 years, $2.4 billion. But over the second 5 years, over the 10-year course of this bill, it loses nearly $5 billion, $4.9 billion. This is a shortsighted way to pay for the bill.

We would be better off to drop the Roth provisions altogether. It would save us a $5 billion hit on the surplus, and we would only have a $7 billion reduction. It is not the way to go if we want to save the surplus for Social Security or protect the fiscal situation that we have worked so hard to get ourselves into.

Mr. BILIRAKIS. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. LAZIO), another member of the subcommittee.

Mr. LAZIO of New York. Mr. Speaker, I want to begin by thanking the three chairmen of the subcommittees, the gentleman from Florida (Mr. BILIRAKIS), the gentleman from California (Mr. THOMPSON), and the full panel chairman, the gentleman from Arizona (Mr. STUMP), for their work on this and both sides on the aisle, quite frankly, for this critical piece of health care that helps Americans stay in their own home, protects families, keeps them together, builds stronger communities, gives seniors and those who are disabled, who are facing critical life choices the peace of mind of knowing that, if they are afflicted with a life-threatening disease, that the system will back them up.

This current reimbursement system clearly undermines, I think, the best of what home health care has provided. The current system reduces payments to New York home health agencies by nearly $130 million, including some of the most efficient and cost-effective home health care agencies.

The ultimate result is that New York seniors are threatened with losing their home health care. At a time when moms and dads are trying to live their retirement years in comfort, the current system undermines their peace of mind. With hard work and leadership from the Committee on Commerce, the Committee on Ways and Means and the Committee on Veterans' Affairs, I am pleased that this bill provides the peace of mind that our seniors need.

During the past year, I have worked with home health care providers in New York to save them and the care that they provide to our seniors. The new reimbursement system for home health care agencies which was developed in the Balanced Budget Act of 1997, the interim payment system, has unintentionally and negatively affected New York residents.

For example, in my district, Southside Hospital's Home Care Agency is expecting a loss of 31 percent this year. That means Southside will lose $1.2 million! The personal security of hundreds of seniors, my friends and neighbors, is threatened.

The New York home health care system is one of the most efficient home care industries in the nation. We are one of the best. Nevertheless, the current reimbursement system reduces payments to New York home health agencies by nearly $130 million in 1998!

The unintended result of this new system is that New York seniors are theatened with losing their health care. At a time when moms and dads are trying to live their retirement years in comfort, the current IPS system pulls the rug out from them. This is the reason why I have worked so hard to address this system and make changes to it to ensure that our seniors—our family, friends, and neighbors—can receive the care they deserve.

With hard work and leadership from both sides of the aisle, I am pleased that the legislation offered on the floor today provides about 1.5 billion dollars to home health care throughout the nation. Only with this money can seniors recover the quality health care they have earned.

The home health provisions before us are supported by the Health Care Association of New York State, the Home Care Association of New York State, and the esteemed Governor from New York.

The bill raises the per beneficiary cap for agencies that have maintained low costs. We should reward the efficient New York providers, not punish them. The bill does not pit agencies against one another. It does not pit one region of the country against another.

Now, Long Island providers will not have to shut down and force our seniors into institutionalized care.

This bill meets two of the loftiest standards of a civilized society—maintaining a senior's dignity—and keeping them active in their communitry during their golden years. The alternative is to penalize the most vulnerable in our society simply for growing old.

I urge my colleagues to vote for the Medicare and Veterans Health Improvement Act of 1998.

Mr. KLINK. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) who is a nurse, is well respected on matters not only on health care but a great many issues.

(Ms. EDDIE BERNICE JOHNSON of Texas asked and was given permission to revise and extend her remarks.)

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in support of this bill and want to thank the leadership on both sides of the aisle for bringing it. I cannot support it wholeheartedly, however, without bringing a few things to my colleague's attention.

I am from a big State with lots of miles, and the new agencies that cover many of those remote-located patients will not be helped by this bill.

We also need to do something about the 15 percent slash that is due next year before that time. I want to associate myself with the remarks of the ranking member of the Committee on Banking and Financial Services, because that is the concern that I have.

While we are creating a tax loophole for the highest earners, which raises money in the short run, it will cost us billions and billions of dollars in the long run.

I do have some concerns. I know that we have an emergency and we do need this coverage, but we cannot let it go

without making sure that there is time for correction.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts (Mr. MCGOVERN).

Mr. MCGOVERN. Mr. Speaker, for over a year now, there has been a small group of us who have been fighting to change the home health care provisions in the Balanced Budget Act; and I want to thank my colleague, the gentleman from Rhode Island (Mr. WEYGAND), the gentlewoman from Michigan (Ms. STABENOW), the gentleman from New Jersey (Mr. PAPPAS), and the gentleman from Oklahoma (Mr. COBURN) for their diligence and their determination to try to help fix this problem.

What we have today on the floor amounts, in my opinion, to a very important achievement. I want to publicly thank the gentleman from California (Chairman THOMAS) for bringing this bill to the floor.

This bill could most certainly be improved, but I commend my colleagues for bringing us this far in the process. I hope that we can work quickly with the Senate in these last few days and pass this bill out of Congress in a form that the President can sign.

I urge all my colleagues to support this legislation.

While there are many people that I would like to thank and recognize, I want to thank the people of Massachusetts who have educated me on this issue, the nurses, the doctors, the home health care agency owners and, most important, our Nation's seniors and the critically ill. I was invited into their homes and their workplaces and shown how important this Medicare benefit is in the lives of everyday people.

This Congress made a grave mistake in the Balanced Budget Act with regard to home health care, and this bill will help correct that mistake. I urge my colleagues to support it.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield such time as he may consume to the gentleman from New Jersey (Mr. SAXTON).

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

Mr. SAXTON. Mr. Speaker, I rise in strong support of the Medicare Home Health Care and Veterans Health Care Improvement Act.

Mr. Speaker, I am pleased to come here today to vote for the Medicare Home Health Care and Veterans Health Care Improvement Act.

This bill takes a step in assisting efficient home health agencies around the country that were hit so hard by the Medicare Interim Payment System. The home health agencies of New Jersey have provided exemplary care to the seniors of our State while keeping their costs very low and should not have been unfairly penalized by IPS.

As always, I continue to support efforts to rid the Medicare system of waste, fraud, and abuse. IPS did not fairly address these problems. I do hope that at some time in the very near future, we can revisit this issue and identify and rid Medicare of such fraudulent practices which only hurt our seniors and the quality of care they receive.

Also, Mr. Speaker, while H.R. 4567 does offer much needed relief to the home health providers in my State, the effects of the IPS during FY98 have been extremely detrimental to them. I must request that retroactivity be implemented for low cost agencies as we continue this process.

Mr. Speaker, the 60,000 seniors who live in my district in New Jersey are united behind us and our efforts to fix the IPS.

Thank you Mr. THOMAS and Mr. BILIRAKIS for realizing the needs of cost-effective agencies.

Mr. KLINK. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. GREEN) of the Committee on Commerce.

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

Mr. GREEN. Mr. Speaker, I rise in reluctant support of this legislation, although the veterans' benefit is the definite plus in the bill and makes it worthy in its own right. It is a shame that, after literally months of discussions and hours of meetings, this is the best we could do on home health care.

The best part of the bill is it will not hurt any home health care agency. Every agency that is affected by this bill will be helped; but in my State of Texas, very few of them will.

However, this bill does not address the looming 15 percent cut in payments to agencies that is right around the corner. It does not address the problems most agencies will face when they receive their demand letters from HCFA. So, despite our efforts today, many home health care agencies could be forced to close, only because HCFA did not notify of them of their IPS rate until as late as July.

Mr. Speaker, H.R. 4567 is not the home health care fix most of us had hoped for. But it is a start in the right direction, and I look forward to properly addressing all of the other problems the IPS has caused at the start of the next session of Congress.

Mr. STARK. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Vermont (Mr. SANDERS).

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

Mr. Speaker, home health care agencies that do a terrific job in serving some of the most vulnerable and frail people in the State of Vermont have lost substantial funding because of an absurd formula that was put in place last year.

This bill begins to address the inequities of that unfair formula and would increase funding for home care, home health care agencies in Vermont and throughout this country that are cost effective and efficient.

Unfortunately, the funding approach for improving this formula is not adequate; and my hope is that, in conference committee, it can be changed. But, most importantly, this is a step forward to addressing a real crisis in home health care funding that exists in Vermont and other States where agencies have been cost effective and efficient. I urge support for this legislation.

Mr. KLINK. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Massachusetts (Mr. MARKEY), a member of the Committee on Commerce.

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Mr. MARKEY. Mr. Speaker, this is a good bill; not perfect, but it is good.

My mother passed away in July afflicted by Alzheimer's for 10 years. We kept her in our home. My father, who is 87, tended to her every single day all day long for 10 years.

The only way that that was possible was for the home health care aide to give him some help in the course of each day. It is very difficult for people who want to tend to this population, which will number in the millions as each year goes by, as the baby boomers get old, for us to allow people who want to avoid the indignities of nursing homes, which my father wanted to do for my mother, because he wanted to honor her by keeping her in the house, in our house that she never left, except when she was hospitalized for diseases unrelated to Alzheimer's.

This bill is critically important for millions of families who want to offer the same kind of protections for their loved ones. I hope that it passes unanimously.

Mr. BILIRAKIS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. STEARNS), a member of the subcommittee.

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

Mr. STEARNS. Mr. Speaker, this is very important legislation. We just have to hope and pray that it actually gets through the Congress this year.

Medicare-eligible veterans are too often shut out of the VA health care system, particularly if they are low-income and services-connected in the rural parts of this country.

This bill would, for the first time, enable Medicare-eligible veterans to bring their Medicare benefits to the VA. It is an important step to provide improved access and equity. Importantly, this bill can also reduce Medicare costs for the care of these beneficiaries.

Dealing with the home health care side of it, I share with the gentleman from Massachusetts (Mr. MARKEY) the same sentiments, because we cared for my mother in our home for over 10 years, too.

I support implementing the new IPS blend that is more equitable than the present system. Furthermore, new agencies must not be penalized and should receive treatment similar to other existing agencies. I note, of course, for my colleagues from Florida, it increases the home health care payment by at least 5 percent.

Medicare is a vast complicated program to begin with and the changes that will occur

over the next few years are bound to compound the frustration and fear seniors already feel about this program.

I think we all recognize that home health care is vital to many of our Medicare recipients and nobody wants to see our seniors suffer needlessly. We all remember the many witnesses who testified about home health care organizations that had bilked the Medicare program out of billions of dollars. Our intention was to reduce unnecessary and fraudulent spending in home health. I believe we were right in setting out to rid the medicare program of fly-by-night organizations that cost the program money that could have been spent on taking care of the needs of seniors.

However, the Interim Payment System now in place is a disaster for rural areas and must be corrected. I support implementing a new IPS blend that is more equitable than the present system. Furthermore, new agencies must not be penalized and should receive treatment similar to that of existing agencies.

This bill addresses these problems by requiring the Secretary to report back to Congress by January 1, 1999 with a time line for implementation of the new system so that Congress will have an opportunity to weigh in and closely monitor its progression. Furthermore, the Administration is charged with making an alternative to the 15-percent reductions that will occur on October 1, 1999. Hopefully, we can alleviate some of the difficulties Medicare home health care beneficiaries have been experiencing for the past few months.

Finally, I would like to indicate my support for the portion of this legislation that was initially introduced as H.R. 3511. The bill will give HHS the discretion to determine, for example, whether allowing physicians to waive the Medicare copayment and deductible requirements for Medicare recipients who participate in particular health care program would open the door to fraud or abuse in the Medicare program. If not, HHS is authorized to issue an advisory opinion permitting the waiver of these requirements with regard to those services.

These provisions of the legislation are critically important to programs such as the National Eye Care Project (NECP), which provide critical health care services to American senior citizens. The National Eye Care Program is the largest and most sustained public service project in American medicine, and is currently sponsored by the Foundation of the American Academy of Ophthalmology and the Knights Templar Eye Foundation, Inc. The program currently has 7,500 participating volunteer ophthalmologists, who examined over 110,000 seniors since 1986. Of those examined, over 70% were diagnosed with an eye disease requiring follow-up care. The program has been recognized by the White House, multiple U.S. Senators and Congressman, the American Medical Association, and the American College of Surgeons.

The program works by matching callers to a toll-free Help line with one of the 7,500 volunteer ophthalmologists nationwide. The physician then provides a comprehensive medical eye examination and treatment for conditions diagnosed at the initial visit. Any financially disadvantaged senior who is a U.S. citizen or legal resident and has no access to an ophthalmologist is eligible to participate.

From the program's inception in 1986 until the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), participating doctors could waive copayment charges and accept insurance reimbursement as payment in full. However, unfortunate technical language found in HIPAA restricted the NECP's participating doctors to waiving fees only for those in financial need. This has forced the NECP to add a means test to their Help line. This test asks questions that financially needy seniors may find embarrassing, such as 'does your financial situation prevent you from seeking eye care?' This means test has unfortunately led to a decrease in the number of seniors seeking care, and has turned away seniors that otherwise would have received treatment.

That's why the pending legislation is so important—it does nothing to dilute the tough anti-fraud and abuse provisions found in HIPAA, while giving the Secretary of Health and Human Services the authority to provide a common sense exemption from payment requirements for the NECP, or for other programs that benefit the public welfare.

Congress needs to allow doctors participating in the NECP to continue their work unhindered and to encourage seniors to utilize the program. More than 50% of all new cases of blindness each year occur in the elderly, at least half of which are preventable. Eye diseases are among the most debilitating and prevalent problems facing the elderly, many of which display no outward symptoms until irreparable damage to their eye sight is imminent.

Mr. Speaker, I urge my colleagues to support this important legislation.

This is important legislation for America's veterans. Medicare-eligible veterans are too often shut out of the VA health care system.

This bill for the first time would enable Medicare-eligible veterans to bring their Medicare benefits to VA. It is an important step to provide improved access and equity.

Importantly, this bill can also reduce Medicare costs for the care of these beneficiaries.–

Mr. KLINK. Mr. Speaker, I yield the remainder of the time to the gentleman from New York (Mr. ENGEL).

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

Mr. ENGEL. Mr. Speaker, I want to express my strong support for this home health care bill.

In April I introduced the Medicare Home Health Agency Efficiency Act, and I am pleased that H.R. 4567 addresses many of my concerns and, in the end, creates greater equity for all home health care agencies. I hope that we can in the next Congress and in conference continue to work on the problems that still face home health care agencies and my constituents. The current reimbursement system in New York penalizes the most efficient home care agencies and without this legislation, home care agencies in New York would have to close and deprive people of vitally-needed services.

I strongly support the concept of home health care. I have a story also. My father, before he passed away, we kept him in our home, and without home health care services, we could not have done this.

So I think this is a good first step, it is a good step in the right direction, and we need to keep on working on this problem. I commend my colleagues for doing this.

Mr. Speaker, I yield the remainder of my time to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I think it is a good bill, too, and I think we need to work on the IPS, and I would hope that we would be able to continue to work on the interim payments and work with the gentleman as well on his legislation.

Mr. STARK. Mr. Speaker, I am happy to yield 1 minute to the distinguished gentleman from Rhode Island (Mr. WEYGAND).

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

Mr. WEYGAND. Mr. Speaker, I want to thank the gentleman from California (Mr. STARK) for yielding me this time.

I also would like to take a moment to thank some of my colleagues who have been very helpful in putting this bill together and working together, and that is particularly the gentleman from Massachusetts (Mr. MCGOVERN), the gentleman from Oklahoma (Mr. COBURN), and, in particular, the gentleman from Maryland (Mr. CARDIN), and the gentlewoman from Michigan (Ms. STABENOW). We have all worked over the last year and a half to try to bring this bill to fruition.

Last year we made a horrible mistake in passing a budget that included an interim payment system that was intended to take away fraud and abuse from wasteful agencies, but it also did a terrible thing. It took the most efficient and effective agencies and cut them as well.

In my State I have seen VNAs go out of business. A VNA that was in business for 87 years serving the needy had to close its doors, others have laid off people, because of this interim payment system.

This past spring we were lucky to get an amendment through in the budget that put us in this direction. This is a good first step, and I compliment the gentleman from California (Mr. THOMAS) for bringing it before us today. But there are other parts of this that have not been addressed that we must address in the near future.

Retroactivity. The 1999 interim payment assistance was supposed to go into a PPS. I hope that we will address those; I hope that we will have a future for our needy people in the home health care system, and I ask my colleagues to support this.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentlewoman from Michigan (Ms. STABENOW).

(Ms. STABENOW asked and was given permission to revise and extend her remarks.)

Ms. STABENOW. Mr. Speaker, I would join with my friend from Rhode Island in thanking everyone who has been involved in this issue. But I also would join today with those who express great concern about the bill that is in front of us.

It has been said that there are no losers as it relates to home health care in this bill. The difficulty is, for me in representing my constituency in Michigan, there are also no winners in this bill.

It has been estimated that in Michigan almost half of our home health care agencies will no longer be able to serve Medicare patients by the end of this year, almost half of those who provide home health care now.

In Michigan, unfortunately, on average, this bill provides only $58.00 in additional home health care services, $58.00 to agencies that are already tremendously efficient providing quality home health care. This is not enough of a fix. This does not, in fact, stop the 15 percent cut for next year.

I urge the conference committee create a better solution so we can provide quality home health care into the future.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from West Virginia (Mr. RAHALL).

Mr. RAHALL. Mr. Speaker, I thank the gentleman from California for yielding.

Mr. Speaker, I am not opposed to the improved payment system for kidney disease patients contained in this bill. Nor am I opposed to the commendable veteran benefits contained herein. I am, however, deeply concerned about the bill's home health provisions as many of my other colleagues have already expressed.

This bill that is masquerading as an appropriate remedy for the devastating effects of last year's BBA, which imposed an interim payment system on our Nation's home health care agencies, the only specialists we have who serve homebound disabled seniors, and the effect has been to drive thousands out of business and deprive seniors of adequate access to care to which they are entitled.

The home health care provisions of the BBA call for paying home health care agencies in 1994 dollars, and since January this year more than 1,100 have gone out of business or have been forced to stop serving Medicare patients because they cannot afford it.

The problem, Mr. Speaker, is pure and simple, that the Thomas bill, however well intended, is not the proper response to the Nation's home health care problem. It does no harm and it does no good, as has already been stated. It is paying mere lip service to the problem of the interim payment system, and I do hope we can address this in the next session of Congress.

Mr. BILIRAKIS. Mr. Speaker, I yield the balance of my time to the gentleman from New Jersey (Mr. PAPPAS), who has been a stalwart on this issue.

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

Mr. PAPPAS. Mr. Speaker, Judy Stanley and Steve Snyder approached me last December about an issue which prompted my introducing of H.R. 3567, gained 106 cosponsors and I have worked hard to find a solution to the problems the home health IPSs cause New Jersey and other states.

Let me thank the gentleman from Arizona (Mr. STUMP), the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from California (Mr. THOMAS) and their staffs for all their hard work. I will support the compromise as a needed step to move forward but I am disappointed that the bill does not do more to improve the viability of low cost agencies.

This bill does not curb the spending patterns of older agencies that have had high costs. Addressing that issue is an important part of preparing the home health industry for perspective payment. It also does not address the automatic 15 percent reduction in reimbursement.

Finally, I am hopeful that the final product will contain retroactivity, which CBO has already scored as costing $200 million. Narrowly tailoring retroactive relief to low cost States or regions would reduce this cost even more. I encourage my colleagues to see if these remaining issues can be addressed in the final package and I urge my colleagues to support it.

Mr. STARK. Mr. Speaker, I yield myself the remainder of the time.

Mr. Speaker, I again join with many of my colleagues who support the tenor of the bill but have serious reservations about its budget implications. I would hope that if there is a chance to revisit this bill we can find a more sensible way to pay for it.

Further, I would like to, in the spirit of bipartisan suggestion, urge the distinguished chairman of the subcommittee, the gentleman from California (Mr. THOMAS), to hark back to the eighties when we tried in the Pepper Commission to develop a long-term care proposal.

Let no one make any mistakes. This growth in home health care has been generated by the lack of any ability to pay for long-term care in the Medicare system.

Rather than see the industry sneak a long-term care policy into the back door of acute care Medicare, we should honestly propose and debate a long-term care social insurance program. If it were fairly presented, with the problems in long-term care discussed, I think we could find a way to include it in the Medicare system rather than tinkering with ways to squeeze down the cost of home health.

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

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

Mr. Speaker, I include at this point in the RECORD a detailed explanation of the bill.

EXPLANATION OF H.R. 4567—MEDICARE HOME HEALTH AND VETERANS HEALTH CARE IMPROVEMENT ACT OF 1998

TITLE I. MEDICARE HOME HEALTH CARE INTERIM PAYMENT SYSTEM REFINEMENT

Current Law

Section 4602 of the Balanced Budget Act established interim payments for Medicare home health care agencies until implementation of the Prospective Payment System on October 1, 1999. Agencies are currently paid their costs up to two limits. The limits are applied when an agency settles its cost report with Medicare. The first limit—the per visit limit—is based on the mix of visits the agency provided to Medicare patients during the year. The per visit limits are based on 105 percent of the median costs by category of services. The second limit—the per beneficiary limit—is based 75 percent on an agency's historical cost per beneficiary and 25 percent on the average per beneficiary historical costs for the region in which the agency is located (both are reduced by 2 percent and are adjusted by the home health market basket). Agencies whose first full year cost report began after October 1, 1993 receive the national median of the per beneficiary limits.

Explanation of Provision

The bill contains a modified version of H.R. 4567. The amendment would increase the per visit limits to 108 percent of the national median costs. In addition, the amendment would increase the per beneficiary limit for many agencies. For those agencies whose per beneficiary limit is below the input price adjusted national median limit, the beneficiary limit would be increased by one half of the difference between the agency's per beneficiary limit and the input price adjusted national median limit (without the two percent reduction). Home health agencies whose first full cost report began on or after October 1, 1993 and before October 1, 1998 would receive a new beneficiary cap. The cap would be equal the greater of (1) the national median limit, without the 2 percent adjustment, and (2) a new blended payment equal to 50 percent of the payment established under the Balanced Budget Act and 50 percent based on a new blend. The new blend would be equal to 75 percent of the national median and 25 percent of the regional mean—both decreased by two percent.

Home health agencies which began treating Medicare patients on or after October 1, 1998 would have per beneficiary limits equaling 75 percent of the input price adjusted national median limit, minus two percent. In the case of a home health care agency or home health care branch which existed as of September 15, 1998, the 75 percent of the national median rule would not apply if that branch subsequently becomes a subunit of its parent or a separate agency. Rather, the parent agency's limit at the time the branch becomes a subunit or a separate agency would be used. These changes would have no impact on the Medicare part B monthly premium.

The bill also would require the Secretary of Health and Human Services to submit to Congress a report describing (1) all of the research to date on the development of a prospective payment system for Medicare home health services, (2) a schedule for implementation of the BBA mandated prospective payment system, and (3) the Secretary's recommendations for one or more alternatives to provide savings equal to the estimated savings from the 15 percent reduction in payment limits scheduled for fiscal year 2000. The Medicare Payment Advisory Commission (MedPAC) would be required to submit a report to Congress no later than 60 days after the date that the Secretary submits her report. In addition, MedPAC would have to include in its June 1999 report an analysis of whether changes in law made by the Balanced Budget Act and amended by this section, impede access to home health services. The General Accounting Office would be required to conduct an audit of the Health Care Financing Administration's expenditures for research related to the development

of a prospective payment system for Medicare home health care services.

Reason for Change

The Medicare home health care interim payment system per beneficiary limits are based on one year of historical cost data (from cost reporting period ending in fiscal year 1994). The rates are based on a blend of agency-specific data and regional data. While this blending reduces some of the variation among agencies, there still exists a more than ten-fold difference between the per beneficiary limits across agencies. Some agencies with very lost historical costs have difficulty responding to changes in the mix of patients. This bill would assist the lowest cost agencies by increasing the per beneficiary limits for the agencies below the national median limit. In addition, the amendment would help decrease some of the differences between old and new agencies within a region.

Because of the Administration's recent announcement of a delay in implementing the prospective payment system on October 1, 1999, as required in the Balanced Budget Act, there is considerable concern about the impact of this delay on agencies and beneficiaries receiving home health care services. In order to ensure accountability, the Secretary would be required to report back to Congress by January 1, 1999 with a detailed time line for implementation of the new system so that the progress may be carefully monitored by the Congress. The Administration would also be required to propose recommended alternatives to the 15 percent across-the-board reduction in rates that will occur on October 1, 1999 because of the PPS implementation delay.

Effective Date

Medicare home health agency cost reporting periods beginning on or after October 1, 1998.

TITLE II. VETERANS MEDICARE ACCESS IMPROVEMENT MEDICARE HOME HEALTH CARE INTERIM PAYMENT SYSTEM REFINEMENT

Current Law

Current law generally prohibits other government agencies from receiving reimbursements for providing Medicare-covered services to Medicare-eligible veterans. In general, Medicare does not pay for services furnished by a federal provider of services or other federal agency. The law has thus generally barred payments for services provided to military retirees at Department of Defense (DoD) facilities and for services provided at VA hospitals and clinics. Subvention is the term given to proposals which would permit the U.S. Department of Veterans Affairs to receive reimbursement from the Medicare trust funds for care provided to Medicare-eligible beneficiaries at VA medical facilities.

The Balanced Budget Act of 1997 (BBA 97, P.L. 105–33) authorized a 3-year demonstration project at six sites under which the Secretary of HHS will reimburse the Secretary of DoD from the Medicare trust funds for services furnished to certain Medicare-eligible military retirees and dependents. The demonstration project is to be established through an agreement entered into by the Secretaries. The Balanced Budget Act of 1997 required the Secretary of HHS and VA to jointly submit to Congress a detailed implementation plan for a subvention demonstration project for veterans.

Explanation of Provision

The bill contains the text of H.R. 3828. The amendment would amend Medicare law by adding a new Section 1897 to the Social Security Act—''Improving Veterans' Access to Services.'' The bill would establish a subvention program for low-income veterans and a demonstration project for other veterans so that the Department of Veterans Affairs may offer certain veterans comprehensive Medicare health care services. Section 1897 would authorize VA subvention in certain circumstances. Subvention is the term given to proposals which would permit the Department of Veterans Affairs to receive reimbursement from the Medicare trust funds for care provided to Medicare-eligible beneficiaries at VA medical facilities. The bill specifically aims at helping vulnerable veterans—known in veterans parlance as ''Category A'' veterans—who have either low income or a service-connected disability. The bill also creates a three-year demonstration project to test subvention for other veterans—known as ''Category C'' veterans—who are not low-income or service-disabled.

The bill would create a Medicare subvention program for Category A veterans but limits Category A subvention to three sites for the three years. If the Category A subvention meets certain criteria, then the subvention program may be offered on a national basis. The amendment provides that Medicare payments for the Category A be capped at $50 million in the first year, $75 million in the second year and $100 million in the third. The amendment would also create a Medicare subvention program for Category C veterans (all other veterans) but limits Category C subvention to three sites for three years. The amendment provides that Medicare payments for Category C will be capped at $50 million per year for three years.

The bill would require the VA to maintain its current level of services to Medicare-eligible veterans and provides that the Secretary of Health & Human Services and the Secretary of Veterans Affairs must monitor expenditure levels during the project in relation to expenditures that would have been made but for subvention.

The bill has provisions which are designed to hold harmless the Medicare Trust Fund, including: (1.) The VA would be paid a discounted rate from the customary Medicare managed care payments (to make up for VA's lower administrative costs); (2.) The VA would be required to institute modern data systems to track the costs and services provided to Medicare-eligible veterans; (3.) The VA would be required to maintain the same level-of-effort that it now provides to Medicare-eligible veterans; (4.) The VA's subvention services would be audited by the Comptroller General and the Inspector General.

Effective Date

The Category C demonstration project could begin as early as January 1, 1999 and end on three years after the commencement. The Category A program would begin on January 1, 2000 at the designated sites.

TITLE III. AUTHORIZATION OF ADDITIONAL EXCEPTIONS TO IMPOSITION OF PENALTIES FOR CERTAIN INDUCEMENTS

Current Law

Current law prohibits medical facilities from making improper inducements in order to attract patients. Because of this, medical facilities have scaled back financial assistance programs which help patients, (e.g., programs to pay patient Medicare Part B and Medigap premiums) lest these programs be construed as improper inducements.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contained a number of provisions designed to toughen fraud and abuse enforcement. One provision—Section 231(h)(1)(C)(5) of HIPAA—prohibited medical facilities from offering patients any kind of inducement to receive services from any particular medical provider. This provision was designed to prevent kickbacks which the Inspector General reported was occurring in some circumstances.

Explanation of Provision

The bill contains the text of H.R. 3511. The amendment would affect the HIPAA provision in several ways: First, the Inspector General of the Health and Human Services Department could create exceptions—known as ''safe harbors''—to the fraud and abuse rules so as to exclude specific practices from the HIPAA provisions. Second, the bill would allow medical facilities to obtain advisory opinions from the Inspector General. These opinions would provide legal and regulatory guidance to medical facilities as to whether payment of coinsurance or other premiums violates HIPAA's fraud and abuse provisions. Finally, the bill would also give the Secretary of HHS interim final rulemaking authority which would speed up the process whereby these safe harbors and advisory opinions become effective.

Reason for Change

Prior to the enactment of HIPAA, specialized medical facilities, such as dialysis centers, operated programs to help their patients afford medical treatment. Examples of these programs included paying patients' Medicare Part B premiums; giving patients free eye-glasses and other services designed to assist patients. The effect of the HIPAA fraud and abuse provision was to discourage medical facilities from offering programs to help patients lest these programs be seen as inducements for patients to receive services from the particular medical facility. This bill gives the Inspector General the authority to make exceptions and to establish safeguards which would permit an exception to the HIPAA provision.

Effective Date

Upon enactment.

TITLE IV. EXPANSION OF MEMBERSHIP OF THE MEDICARE PAYMENT ADVISORY COMMISSION

Current Law

The Balanced Budget Act of 1997, Public Law 105–33, established the Medicare Payment Advisory Commission (MedPAC) as a result of merging two commissions, the Prospective Payment Advisory Commission and the Physician Payment Review Commission. MedPAC, like its predecessors, is a nonpartisan commission which advises Congress and makes recommendations regarding Medicare payment policies.

Section 4022 of the Balanced Budget Act detailed the criteria for membership on the Commission: The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

MedPAC commissioners are appointed by the Comptroller General and serve terms of three years. The Balanced Budget Act authorizes the Commission to have fifteen commissioners.

Explanation of Provision

The bill contains the text of H.R. 4377. The amendment would add two commissioners to MedPAC.

Reason for Change

The addition of two commissioners would enable the commission to reflect more fully

the diversity of backgrounds and interests in the health policy community. Expanding the number of commissioners would not only allow for a greater range of professional expertise but also a more diverse representation from various parts of the country.

Effective Date

May 1999.

TITLE V. REVENUE OFFSET

Current Law

Taxpayers (single or married) may roll their ''traditional IRA'' over into a ''Roth-IRA'' if their adjusted-gross-income (AGI) does not exceed $100,000. Married taxpayers, filing separately, cannot roll their traditional IRA into a Roth-IRA.

Explanation of Provision

The bill would allow single taxpayers with adjusted gross income of $145,000 and married taxpayers with AGI of $290,000 to roll their traditional IRA into a Roth-IRA. Married tax payers, filing separately with adjusted gross income of $145,000 could also do a Roth rollover.

Reason for Change

The current rules impose unwarranted restrictions on taxpayers based merely on their marital status and thus prevent certain taxpayers from adequately providing for their retirement years.

Effective Date

Distributions after December 31, 1998.

Mr. Speaker, I can assure the Members no one is more aware of the modest scope of this bill than I am. It is a very modest correction to the interim payment system. Included in the bill is a request that the secretary provide us with some offset proposals for the 15 percent reduction that I know concerns a number of individuals. It is clear it does not take care of the home health care problems. It does not address long-term care concerns.

The Medicare Commission is currently examining those chronic concerns that face seniors today and all Americans tomorrow. Ongoing oversight of the Health Care Financing Administration is absolutely critical.

This is a modest proposal on the interim payment system. We will continue to examine the changes that are occurring in the home health care industry, but for the veteran subvention, for the modest protection for the end-stage renal disease individuals, for the expansion of the MedPAC Advisory Board, I would ask for an aye vote.

Mr. GUTIERREZ. Mr. Speaker, I rise today in support of the Veterans Programs Enhancement Act of 1998. I commend Chairman STUMP and Ranking Member EVANS for their tireless effort in producing this important legislation.

I also compliment the staff of both the House and Senate Veterans' Affairs Committees. Their hard work and dedication to our veterans has made this legislation possible.

People outside of this building are often unaware of the vital role staff play in the legislative process. They should not be. Our veterans should know how hard the veterans committee staff works for them each day. I hold this bill up as testament to their efforts.

Mr. Speaker, for much of this year I was not sure what this Congress would be able to accomplish on behalf of our nation's veterans.

I would venture to say that this Congress's record on veterans issues has been mediocre at best. Funding for veterans health care was cut again, medicare subvention was not achieved and veterans benefits were slashed to fund highway construction.

But in the end, with the passage of this legislation, we will be able to point to some notable achievements on veterans issues this year.

With this bill, we establish a precedent for the presumptive treatment and compensation of Persian Gulf War veterans.

I have long felt that we must give our Gulf War veterans the benefit of the doubt when it comes to health care and service connection. This bill helps us reach this goal that I have long called for.

In addition, this legislation helps prepare us to provide quality treatment for the veterans of future conflicts.

We were unprepared for the aftermath of the Gulf War.

However, by establishing a National Center for the Study of War-Related Illnesses, this bill helps prepare our veterans health system for the aftermath of future conflicts.

This bill also extends the VA's authority to treat the medical problems afflicting Gulf War veterans until 2001. We know we are not through dealing with the health problems confronting Gulf War veterans and I am pleased to see this fact recognized in this legislation.

The VA's sexual trauma treatment program, a program that I have advocated for throughout this session, is also reauthorized by this bill. During the past two years, the reality of sexual abuse and harassment of women in the military has come to light. It is only right that we maintain the VA's capacity to offer the victims of these crimes the treatment they need and deserve.

In addition, I am also pleased by this bill's provisions regarding educational opportunities, housing and medical construction at veterans hospitals. The reforms contained here are necessary and well-intentioned and should contribute to the welfare of veterans throughout America.

I am proud to support this bipartisan bill. And I urge my colleagues in the House to support this legislation as well.

Mr. ADAM SMITH of Washington. Mr. Speaker, I would like to take this opportunity to express my strong support for making changes to the home health care interim payment system (IPS). As part of the $16.2 billion in savings from home health over five years, the Balanced Budget Act of 1997 created an interim payment system to serve as a bridge until the prospective payment system could be implemented. While the interim payment system was designed to cut costs and reduce fraud, it has unfairly punished the efficient home health agencies throughout the country, including those of Washington state.

In the 1980s, the federal government promoted home care as a way to improve the health care situation in the United States. Using home care services reduces hospitalization, cuts the demand for expensive nursing homes, eases the burden on family caregivers and is proven to help sick people get better faster. Increased use of these services has helped make the health care system more efficient and better for consumers. While home health services have improved health care for many individuals, Congress could not ignore the increased costs and fraud in the home health system in recent years, and we acknowledged changes need to be made. Unfortunately, Congress did not make the correct changes in the process.

My primary concern with the changes in the Balanced Budget Act of 1997 relating to home health care payments is that in interim payment system disproportionately punishes areas of the country where home health patients are served efficiently. Washington state has been especially effective in their use of home health care. The state's home health care systems is one of the most efficient in the country. The typical home health patient in Washington state uses only about 34 visits per year, which is less than half of the national average. Efficient agencies should be rewarded, not punished, under the new system and I believe Congress must fix the changes they made as part of the BBA to assure we do not unfairly punish those who have done their job well.

I strongly support this bill because I believe it is a good step in the right direction for addressing the problems in the home health interim payment system. I feet we must continue to address this issue in the future to assure we are not punishing the home health agencies that provide services efficiently.

Mr. MORAN of Kansas. Mr. Speaker, I rise today in support of H.R. 4567, the Medicare Home Health Care Improvement Act. Last year's changes to Medicare made across the board cuts to home health funding that have been devastating to many agencies and their patients, particularly in states with the lowest historical costs.

Mr. Speaker, this legislation would provide critically needed relief for our seniors needing home health care. In my home state of Kansas, a number of agencies have already closed their doors. For the seniors that I represent in rural areas and smaller communities, the loss of their home health agency, too often means the loss of critical services.

While this legislation is not a perfect solution, it represents an important step. We simply cannot afford to close this session of Congress without addressing the dire circumstances facing our seniors. I urge my colleagues to support this legislation.

Mr. DUNCAN. Mr. Speaker, I feel that there are segments of the healthcare community that are under-represented on the Medicare Payment Advisory Commission (MedPAC).

Specifically, there is a notable lack of input and expertise from the medical supply industry. These manufacturers must overcome technological and clinical challenges during the development, production, and distribution of medical supplies. I believe that the insight derived from this market experience supports the appointment of someone from the medical supply industry to the MedPAC.

I am told that 25 to 30 percent of the current cost of Medicare involves medical supplies. Since MedPAC will review and make recommendations to the Congress concerning Medicare payment policies, I think it is clearly prudent to have this segment of the healthcare industry represented in any future appointments.

Also, if MedPAC is to make recommendations on procurement issues, including the impact and cost of competitive-bidding for effective medical products, it is appropriate to ensure that someone from the medical supply industry serve as a MedPAC commissioner. Although I do not wish to amend the bill to require representation of any specific industry, I

do want to recommend that consideration be given to the appointment to MedPAC of a recognized professional from the medical supply industry.

Mr. MENENDEZ. Mr. Speaker, the Balanced Budget Act of 1997 put the home health care industry on a prospective payment system, and set up an interim payment system for agencies until the prospective payment system could be fully implemented.

Unfortunately, those home health agencies which have historically been fiscally responsible in their administration of federal dollars have been penalized for good program management.

In my state of New Jersey, the home health industry has been aggressive in its management of resources. New Jersey's annual average for visits per beneficiary served is only 39.7. The national average is 66 visits per year, and some states have numbers as high as 125 visits per beneficiary! So the message has been that it doesn't pay to be prudent with federal dollars.

HCFA's regulations have not so much penalized those states which have had excessive costs as they have mandated that all states—including those states with the lowest number of beneficiary visits—bear the financial costs in an across-the-board distribution of the effort to rein in the costs for this industry.

The bill we are adopting today, H.R. 4567, is a step in the right direction. However, there is a basic sense of fairness which is missed in the ''hold harmless'' provisions. It is my sincere hope that as this bill is conferenced some measure of equity is brought into the negotiations which will recognize the efforts of those states which have been in the lowest 20 percentile of costs in the home health care industry. If they are not rewarded for their prudent handling of this program, they should at the very least not be penalized.

Mr. BLILEY. Mr. Speaker, I rise in support of the Medicare Home Health Care and Veterans Health Care Improvement Act, H.R. 4567. This measure is a monumental step forward in expanding quality health care coverage to millions of Americans.

This legislation is the result of a true cooperative spirit between the Commerce and Ways and Means Committee, and would like to personally thank Chairman ARCHER and Congressmen BILIRAKIS and THOMAS for all their hard work on this effort.

While there are a number of important provisions in this bill, I would like to focus solely on two—home health care and VA subvention.

First, nearly one out of every ten Medicare recipients receives home care, with an average of 80 home health visits each. In the Balanced Budget Agreement of 1997, Congress and the Administration sought to restrain the growth in these costs by going to a prospective payment system.

However, before this plan could be implemented, HCFA had to implement a supposed ''short term'', or interim, payment system that would help the agency and the industry move to this new billing system. Unfortunately, HHS and HCFA have failed to implement a policy that is equitable to all home health agencies.

Our bill recognizes the importance of this benefit to our nation's elderly, while reaffirming our commitment to the Balanced Budget Agreement.

Our home health reforms build on three simple, yet crucial principles:

(1) equity, resolving the arbitrary differences inadvertently created by the Balanced Budget Act of 1997;

(2) transitional sensitivity, helping home health agencies not only survive the interim payment system but also place them squarely on the track for the impending prospective payment system; and

(3) implementability, guaranteeing that HCFA can immediately put into effect the reforms we authorize.

Secondly, all of us understand and appreciate the importance of maintaining our nation's commitments to our nation's servicemen and women, and there is no stronger commitment made to our veterans than the guarantee of quality health care.

By allowing Medicare-eligible veterans to use their Medicare benefits in VA facilities, we are not only helping veterans get their care when and where they feel most comfortable, but we are also helping the VA reach out to those veterans who have fallen through the cracks or are under-served.

In closing, the Medicare and Veterans Health Improvement Act is a major step forward for our nation's seniors and they deserve no less than the fullest measure of our support.

Mr. Speaker, I ask my colleagues for their strong support of this legislation.

Mrs. ROUKEMA. Mr. Speaker, I rise in support of this legislation which moves us in the right direction for saving home health care in New Jersey. Yet, I do wish we could do more.

The proposed Medicare interim payment system would have the effect of punishing the efficient, low cost home health providers. This proposal before us today will help soften that blow by adjusting the per beneficiary limit.

THE PER-BENEFICIARY LIMIT

One of the flaws with the proposed interim payment system policy was in the formula to calculate the per beneficiary limit. Because reductions are made based on agency specific data and regional average costs, expensive agencies who are driving the increase in growth and costs in this industry continue to function at a much higher rate than that of more efficient and less costly ones.

In New Jersey this would mean that New Jersey would receive a reimbursement less than that of the national median.

This bill before us today would bring up those states that are below the national median limit, closer to that national median.

RETROACTIVITY

But I do wish that we could make this legislation retroactive. By not making this legislation retroactive we have left agencies to work under the great financial burdens caused by the interim payment system.

I do hope that we can move this bill forward, but we do still have some work to do.

Mr. BEREUTER. Mr. Speaker, this Member rises today as a co-sponsor and strong supporter or H.R. 4567. When Congress passed the Balanced Budget Act last year, we made some very important changes to Medicare that will insure its availability for seniors well into the next century. However, Congress went a little too far in the area of home health. In an attempt to eliminate the waste, fraud and abuse that did exist in the home health care industry, the Medicare interim payment system, which was created last year, instead hurt some of the most cost-conscious agencies that have worked hard over the years to keep costs low.

For example, one of the home health agencies in this Member's district in Beatrice, NE, was told earlier this year by their intermediary that under IPS they would receive a Medicare reimbursement limit of about $1,600 per beneficiary. That's over $700 less than the regional average of $2,341 per beneficiary, and $2,200 less than the national average reimbursement per beneficiary of $3,862. A reimbursement limit of $1,600 a year is simply not enough money in many cases where a home health agency needs to treat a disabled, elderly individual. To make matters worse, the only other home health agency in the town of Beatrice went out of business this summer, mostly due to its low Medicare home health reimbursement rate.

Even worse, HCFA has announced that they cannot implement a permanent, perspective payment system by their October 1, 1999, deadline because of their Y2K problems. Therefore, under current law, home health agencies will not face an additional reduction of 15 percent in their per-beneficiary reimbursement. Under this system, home health agencies, especially those in rural areas, will go out of business—this unfortunate situation will occur in areas of many States, including Nebraska, with the end result being that these areas will have no home health services available. Under this system, Medicare beneficiaries will suffer.

H.R. 4567 begins to correct the problem with the interim payment system and will allow these agencies to stay in business until a prospective payment system is implemented. It increases the per beneficiary reimbursement to those agencies whose limit is below the national median limit—which will help almost every agency in this Member's district. It also directs HCFA to send Congress a report on its progress, if any, on implementing a prospective payment system. Finally, H.R. 4567 asks the Secretary of Health and Human Services to help Congress find a way to prevent the 15 percent reduction in payment limits scheduled for October 1, 1999.

Mr. Speaker, this Member cannot emphasize enough the importance of passing legislation that will correct the flaws of the IPS. Congress must pass legislation before the end of this session in order to save the hundreds of home health agencies all over the country that will no longer be able to provide care next year if the current payment system is allowed to remain in place. This Member asks all of his colleagues to support this critical measure for all of the elderly constituents receiving home health in their district.

Mr. RODRIGUEZ. Mr. Speaker, I would like to support H.R. 4567 with enthusiasm. This bill on its surface aims to improve veterans heatlh and correct serious deficiencies in our home health reimbursement system. Unfortunately, at least in the home health area, the bill falls woefully short of its stated goal.

For veterans this is the first effort to implement VA-Medicare subvention, which has been sought by veteran's service organizations for years. This legislation would allow veterans who are covered by Medicare to receive treatment at VA facilities. I support subvention and am a co-sponsor of legislation to bring this overdue option to veterans. We own our veterans quality health—for this reason I will vote for this bill today.

However, this bill falls FAR short of addressing the real need of our communities that

rely so heavily on the home health care industry. Home health fills a much needed void for my for my community where very few hospitals exist and nursing home have been closed. How can we expect our elderly Medicare beneficiaries in rural communities to survive when a handful of home health agencies are closing everyday? I have no idea how my constituents are expected to survive. Many of the Medicare beneficiaries that utilize home health have already been told they will not longer receive care and have been left to the hands to fate.

This bill fails to address the pressing problems created by the faulty interim payment system (IPS) and further address the failure of the Health Care Financing Administration to recognize the need in rural communities for such care. HR 4567 fails to recognize two key provisions: the need for retroactivity, and the automatic 15 percent reduction scheduled for this year.

It is a shame that we are not able to bring a bill to the floor that addresses the heart of the home health crisis—access to health care for our elderly. The Republican leadership has failed our elderly by not recognizing that more needs to be done and that it needs to be done now. Our only hope is that REAL changes will be made in the conference version of this bill. If not, we will all surely go home from this session hanging our heads low, knowing that we have not really solved the matter. Instead we have pretended to acknowledge it and then walked away.

Mr. ROTHMAN. Mr. Speaker, I rise today in support of H.R. 4567. I am pleased that this bill includes the text of H.R. 3511, and urge my colleagues to vote in favor of this important legislation. H.R. 3511 is one of those bills that, though technical in nature, can be critically important for those that it may affect.

In fact, for some older Americans, this legislation will mean the difference between spending the remaining years of their lives struggling to overcome the handicap of blindness and having the benefits and opportunities of sight.

H.R. 3511 can make a difference in the lives of our senior citizens because it grants to the Secretary of Health and Human Service (HHS) the discretion needed to allow programs such as the National Eye Care Project (NECP) to provide eye care to all elderly Americans at no out-of-pocket cost to those that it serves. Under current law, ophthalmologists who participate in the National Eye Care Project are required to charge each patient all of the copayments and deductible specified by Medicare—unless, of course, that patient is determined to be finally disadvantaged and lacking the means to pay for medical eye care.

The problem is that many senior citizens will decide not to see an eye doctor if they must answer such intrusive questions as whether making the Medicare copayment would mean they are ''unable to afford food'' or ''be forced to put off paying for such expenses as food, housing, transportation and prescription medication.'' Others who are not ''financially disabled,'' as defined by Medicare, do not believe they can afford the copayments and deductibles, and therefore decide to defer a visit to the eye doctor for another day. Unfortunately, with some eye diseases, a delay of even a few weeks can lead to irreparable damage, and even blindness, which could have been avoided with timely care.

The National Eye Care Project was established by the Foundation of the American Academy of Ophthalmology in 1986 to address this problem. Through a toll-free Helpline, seniors can receive information about common eye diseases and, if eligible, get a referral to one of the approximately 7,500 volunteer ophthalmologists across the country who provides eye care to those in need.

Prior to enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NECP could advertise that it would provide this care ''at no out-of-pocket cost'' to those who need it, and seniors seeking care were not required to answer intrusive questions about whethr they could afford to make Medicare copayments. However, HIPAA made this approach illegal by prohibiting the waiver of Medicare copayments without a case-by-case determination of financial need. H.R. 3511 will remedy this situation by giving the Secretry of Health and Human Services the discretion to allow a program such as the NECP to waive Medicare co-payments for all participants. HHS would not, of course, make such a determination for the NECP of other programs if it could not establish that granting a waiver would not create a loophole for fraud and abuse in the Medicare program. Combating fraud and abuse was the original objective behind HIPAA restrictions.

In conclusion, Mr. Speaker, H.R. 3511 is important legislation that can lead to significant benefits for our senior citizens. I urge my colleagues to vote for this legislation.

Mr. PORTMAN. Mr. Speaker, I rise in support of H.R. 4567, the Medicare Home Health Care and Veterans Health Care Improvement Act. Home health care is a vital service for Medicare beneficiaries that provides patients with peace of mind by allowing them to stay in their homes during their golden years. Without this service, many individuals would be forced into more expensive assisted living facilities or nursing homes.

The bill is necessary because HCFA has told us that, as a result of the Y2K computer problem, it cannot implement the prospective payment system for home healthcare by October 1, 1999 as required by the Balanced Budget Act. This means home health agencies, through no fault of their own, will be hurt by the interim payment system and will continue to be paid under it longer than Congress intended. This unfortunate situation threatens the very existence of many agencies, including some from my Congressional district that have been responsible and have operated efficiently to keep their costs down.

H.R. 4567 is designed to provide needed relief to such agencies under the interim payment system while HCFA sorts out its computer problems. I agree with those agencies that feel additional measures are needed, but that just isn't possible under our current budget constraints. The real solution is for HCFA to redouble its efforts to implement the PPS without further delay. In the meantime, H.R. 4567 will help agencies get through this difficult period.

I urge passage of this bill to ensure that agencies can continue to offer essential health care services to seniors in southwest Ohio and around the nation, and I call on HCFA to do whatever it takes to see that agencies can get out of the interim payment system as soon as possible.

Mr. STARK. Mr. Speaker, this bill is nothing more than a tax break for the wealthy disguised as a Medicare bill. It's a perk for Members of Congress who, along with their spouses, will not be eligible for new tax shelter—Roth IRAs.

We have had no chance to study the home health proposal. Relative to the bill reported out of Ways and Means, it moves money toward new, for-profit agencies, who have been the cause of the home health funding crisis. Many of these agencies have been the very definition of fraud, waste, and abuse.

The health policy in this bill is not as good as the policy in the bill reported from Ways and Means—but it is not bad.

What is horrendous, what is totally unacceptable is the pay for and the budget implications! This bill loses $10.7 billion over 10 years. It is absurd, but true that the Treasury would be better off if the Majority did not try to pay for the bill! With this bill, you are spending the surplus. You are creating a tax loophole for the very upper income, that will cost billions and billions in the out-years—just when we will need the money to save Medicare and extend its life. This proposal is poor tax policy and poor budget policy. We should be saving the surplus for Medicare—not spending it to please some for-profit home health agencies that have been abusing the program. Between now and 2008 when the Medicare Trust Fund will be exhausted, we will need about $325 billion—yet this bill gives away billions and adds to that pending crisis.

Over the next 5 years, Medicare will spend about $1.1 trillion. You would think that we could find zero-point-two (0.2) percent out of current Medicare spending. There is a National Bipartisan Commission on the Future of Medicare that is trying to save Medicare for future generations, but if we can't find 0.2%, and give away billions of dollars that could be saved for Medicare, what does that say about the worth of that Commission? The Majority's pay for will undoubtedly run into budget rules in the Senate, and will be opposed by the Administration. To offer such a pay for smells like a poison pill.

Mr. BONILLA. Mr. Speaker, I rise today in support of H.R. 4567, the Medicare Home Health Care and Veterans Health Care Improvement Act of 1998. This bill provides additional resources for health care for the heroic men and women who are our nation's veterans. However, this bill falls far short of improving the situation that home health care agencies are facing.

The Balanced Budget Act of 1997 directed the Health Care Financing Administration (HCFA) to develop a prospective payment system of reimbursement for home health care agencies by 1999. In the meantime, HCFA developed an interim payment system designed to help health care agencies' transition to a prospective payment system. Unfortunately, this system has jeopardized the health care for many of our most vulnerable citizens and has put many hard-working agencies out of business. In August, the HCFA told Congress that it will not follow the law and develop the prospective payment system. Due to HCFA's inaction, Congress was forced to quickly develop an interim payment system to keep home health care afloat until HCFA can get its act together.

While the bill we are voting on today takes one step forward in that fix, we still have a

long way to go. As we face the last days of this congressional session, I am disappointed that we are faced with a ''take it or leave it'' situation. However, I am supporting today's measure because a little help is better than no help. I am confident that this Congress will continue to have home health reform as its top priority when it returns next year.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today to express my support for H.R. 4567, the Medicare Home Health Care and Veterans Health Care Improvement Act of 1998 and to congratulate the bill's sponsors for moving this important legislation forward before Congress adjourns this year.

While the bill is not perfect, it does promise to help the historically low-cost agencies that have been penalized by the interim payment system (IMPS) implemented in the Balanced Budget Act of 1997 for their past efficiencies in delivering high quality home care. I also applaud the sponsors of the bill for increasing the per visit reimbursement limit.

While I support the bill, I have some reservations. Texas is a big State with large rural areas. I am concerned that reimbursement to new health agencies in rural areas that must travel long distances to serve their patients is too low under the Interim Payment System. H.R. 4567 does little to help these new agencies.

Furthermore, the bill does nothing to postpone the 15% cut scheduled for next fall when HCFA fails to implement the Prospective Payment System by the October 1, 1999 deadline.

I hope to see these issues addressed during conference with the Senate. In addition, I can only hope that a more appropriate funding mechanism can be found in conference that does not create a tax loophole for the highest earners which raises money in the short run and costs us billions in the long run.

Mr. HILLEARY. Mr. Speaker, I would like to give my support, though reluctantly, to H.R. 4567, the Medicare Home Health Care and Veteran Health Care Improvement Act.

First, I would like to extend thanks to Chairman THOMAS, BLILEY, STUMP, ARCHER and BILIRAKIS for their hard work and countless hours spent crafting this legislation. I would also like to thank members from both sides of the aisle who have worked tirelessly on this subject, especially Congressmen RAHALL, ADERHOLT, COBURN, PAPPAS, STABENOW, and WEYGAND. If not for their hard work and perseverance, we would not even have this bill before us today.

This bill does wonderful things for both our veterans and those in need of kidney dialysis treatment. However, it is woefully inadequate in terms of its aid to home health.

For our veterans, it gives those who have served our country so proudly the right to receive Medicare benefits at VA facilities. This bill will open up access and help ease the financial burden that many of our veterans would otherwise face and create more flexibility on their medical care through a process known as ''subvention.'' Under subvention VA facilities would be able to provide efficient and affordable ''one-stop'' shopping for veteran medical services. I am proud to support this initiative.

This bill also does a tremendous job for those kidney patients who need better access to dialysis machines. Under this bill ''safe harbors'' would be created to allow those in need to have a specialized dialysis help subsidize their payments. This would give greater access and make more affordable dialysis machines to the many people who suffer from kidney failure.

However, I must stress my emphatic displeasure with the home health portions of this bill. I do not believe that the home health sections of this bill are bad ideas as written in the bill. Instead, I oppose the glaring omission of several essential elements that must be addressed in order to save this industry that provides health service to so many of our elderly. Among the major deficiencies in the bill are failures to address the agency retroactivity, regional equity, and the impending industry wide 15% cut set to occur next October 1.

I especially find it disheartening that this bill does not even attempt to help every region. In my state of Tennessee, most agencies will not even see a drop of this increase, yet we have already seen 24 closures this year. A regional solution is an incomplete solution.

I do not want to see us simply put a Band-Aid on the problem and pretend that we have done adequate work. By only going halfway on this issue, we have done the home health industry a disservice. For I fear that if we do not address these issues in the next few days, then we will be unable to solve the problems that these issues will create next year.

In particular, I feel that if the 15% cut goes into effect, the entire industry, and the seniors they serve, will be severely impacted. By putting off the problem until next year, the bill merely gives a wink and a nod without offering a solution. I know that if this problem is not addressed, either by establishing a permanent case-mix adjuster or a delay of the 15%, the industry will fail, and we will have this wasted opportunity to blame.

I am completely dumbfounded to why we give a halfhearted solution when we have the opportunity to do so much more. I hope that the issues in this bill are not closed. I hope that we still can address important issues like the impending 15% cut set for next year. If we do not come back next Congress and act quickly, I fear that the sick and elderly will never forgive us for our inaction.

I reluctantly urge my colleagues to support this bill and strongly urge my colleagues and the chairmen overseeing home health care to continue working and address the remaining critical problems facing this industry.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the motion offered by the gentleman from California (Mr. THOMAS) that the House suspend the rules and pass the bill, H.R. 4567, as amended.

The question was taken.

Mr. THOMAS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 5 of rule I and the Chair's prior announcement, further proceedings on this motion will be postponed.

□ 1300

PLANT PATENT AMENDMENTS ACT OF 1997

Mr. SOLOMON. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1197) to amend title 35, United States Code, to protect patent owners against the unauthorized sale of plant parts taken from plants illegally reproduced, and for other purposes.

The Clerk read as follows:

H.R. 1197

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Plant Patent Amendments Act of 1997''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—The Congress makes the following findings:

(1) The protection provided by plant patents under title 35, United States Code, dating back to 1930, has historically benefited American agriculture and horticulture and the public by providing an incentive for breeders to develop new plant varieties.

(2) Domestic and foreign agricultural trade is rapidly expanding and is very different from the trade of the past. An unforeseen ambiguity in the provisions of title 35, United States Code, is undermining the orderly collection of royalties due breeders holding United States plant patents.

(3) Plant parts produced from plants protected by United States plant patents are being taken from illegally reproduced plants and traded in United States markets to the detriment of plant patent holders.

(4) Resulting lost royalty income inhibits investment in domestic research and breeding activities associated with a wide variety of crops—an area where the United States has historically enjoyed a strong international position. Such research is the foundation of a strong horticultural industry.

(5) Infringers producing such plant parts from unauthorized plants enjoy an unfair competitive advantage over producers who pay royalties on varieties protected by United States plant patents.

(b) PURPOSES.—The purposes of this Act are—

(1) to clearly and explicitly provide that title 35, United States Code, protects the owner of a plant patent against the unauthorized sale of plant parts taken from plants illegally reproduced;

(2) to make the protections provided under such title more consistent with those provided breeders of sexually reproduced plants under the Plant Variety Protection Act (7 U.S.C. 2321 and following), as amended by the Plant Variety Protection Act Amendments of 1994 (Public Law 103–349); and

(3) to strengthen the ability of United States plant patent holders to enforce their patent rights with regard to importation of plant parts produced from plants protected by United States plant patents, which are propagated without the authorization of the patent holder.

SEC. 3. AMENDMENT TO TITLE 35, UNITED STATES CODE.

(a) RIGHTS IN PLANT PATENTS.—Section 163 of title 35, United States Code, is amended to read as follows:

''§ 163. Grant

''In the case of a plant patent, the grant shall include the right to exclude others from asexually reproducing the plant, and from using, offering for sale, or selling the plant so reproduced, or any of its parts, throughout the United States, or from importing the plant so reproduced, or any parts thereof, into the United States.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to any plant patent issued on or after the date of the enactment of this Act.

The SPEAKER pro tempore (Mr. LAHOOD). Pursuant to the rule, the