INTRODUCTION OF THE MUSEUM AND LIBRARY SERVICES ACT OF 2003

HON. PETER HOEKSTRA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 2003

Mr. HOEKSTRA. Mr. Speaker, today I am introducing a bill to reauthorize federal assistance to museums and libraries through fiscal year 2009. The Museum and Library Services Act of 2003 maintains the modest but essential federal support for museums and libraries across the country; authorizes funds for the one federal agency—the Institute of Museum and Library Services—devoted exclusively to museums and libraries; and encourages model cooperation between museums and libraries.

Last Congress, the Committee on Education and the Workforce reported H.R. 3784, the Museum and Library Services Act of 2002. That bill had 94 cosponsors, was supported by the Administration, and was endorsed by the American Library Association, the Chief Officers of State Library Agencies and the American Association of Museums.

The Museum and Library Services Act of 2003 makes several modifications to current law to streamline and strengthen museum and library services, and will help build on the bipartisan progress made by the Committee during the 107th Congress.

Generally, this legislation authorizes the federal library and museums program under the Institute of Museum and Library Services. Specifically, the Museum and Library Services Act of 2003: Requires the Director of the Institute of Museum and Library Services to establish procedural standards for making grants available to museums and libraries (ensuring that the criteria are consistent with the statutory purposes); Prohibits projects that are determined to be obscene from receiving funding; Ensures that library activities are coordinated with activities under the No Child Left Behind Act of 2001; Consolidates museum and library advisory board activities under a single statute; Authorizes the IMLS Director to issue National Awards for Library Service and National Awards for Museum Service; and Ensures that administrative funds are also used to conduct annual analyses of the impact of museum and library services to evaluate and identify needs and trends of services provided under funded programs.

The Museum and Library Services Act of 2003 makes common sense reforms to authorized museum and library activities, includes provisions important to Members on both sides of the aisle and reauthorizes a program that should be supported by the Congress.

I hope that my colleagues on both sides of the aisle cosponsor the Museum and Library Services Act of 2003. 1 look forward to completing this legislation this Congress so we can ensure that our nation's museums and libraries are getting the best assistance we are able to provide from the federal level.

COMMENDING THE PEOPLE AND GOVERNMENT OF KENYA

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 2003

Mr. HASTINGS of Florida. Mr. Speaker, I rise today to express my total support for the people and the newly elected government of Kenya. The hard work and perseverance on the part of the people of Kenya is commendable, as they march along the difficult road of peace and democracy. In much of the developing world, we have witnessed, time and again, countries whose efforts have fallen short of that needed to fully implement a democratic tradition.

The determined Kenyan voters ignored unseasonably heavy rains and provided a solid mandate to the new president, the parliament, and local councilors throughout the country. It is refreshing to see the change of government at the ballot box of free and fair elections and not at the end of rifles. Local and international observers who witnessed the election of President Mwai Kibaki described it as the fairest in Kenya's 39–year history. I urge this body to support and commend the Kenyans for the positive measures they have taken to establish a solid democratic foundation.

This body, the House of Representatives, along with the Senate and the executive branch should provide assistance to this country as it continues to build its economy and political institutions.

INTRODUCTION OF THE GERIATRIC CARE ACT OF 2003

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 2003

Mr. GREEN of Texas. Mr. Speaker, I rise today to reintroduce the Geriatric Care Act of 2003, an important piece of legislation which will help our nation prepare for the health care pressures associated with the aging of the baby boom generation.

Americans are living longer than ever, with the average life expectancy rising to 80 years old for women and 74 years old for men. While this is generally a positive development, there are costs associated with the aging of America. As seniors live longer, they face greater risks of disease and disabilities, such as Alzheimer's, diabetes, cancer, stroke, and heart disease.

Geriatricians are physicians who are uniquely trained to help care for the aging and elderly. By promoting a comprehensive approach to health care, including wellness and preventive care, geriatricians can help seniors live longer and healthier lives.

It is critical that our nation have a sufficient number of geriatricians to help manage the aging of the baby-boom generation. Unfortunately, there are currently only 9,000 certified geriatricians, and that number is expected to decline dramatically in the coming years. Of the approximately 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine and geriatric psychiatry. The Alliance for Aging Research estimates that the United States will need approximately 36,000 geriatricians to counter the aging population. We must do more to promote geriatric residency programs.

There are two barriers preventing physicians from entering geriatrics: insufficient Medicare reimbursements for the provision of geriatric care and inadequate training dollars and positions for geriatricians.

A MedPac survey found that Medicare's low reimbursement rates serve as a major obstacle to recruiting new geriatricians. Due to their higher level of chronic disease and multiple prescriptions, seniors require additional care to ensure proper diagnosis and treatment. Medicare's reimbursement rates do not factor the complex needs of elderly patients. Because geriatricians treat seniors exclusively, they are especially affected by Medicare's low reimbursement rates.

Additionally, the Balanced Budget Act placed limits on the numbers of residents a hospital can have, based on 1996 numbers. This cap serves as a disincentive for some hospitals, and has caused them to eliminate or reduce their geriatric Graduate Medical Education (GME) programs.

The legislation I am introducing today would remedy both of these problems, so that America is prepared for the aging baby boom generation. The Geriatric Care Act would modemize the Medicare fee schedule to more accurately reflect the cost of providing care for seniors. It also would allow for additional geriatric residency slots, so that we can develop an adequate supply of geriatricians for the next generation.

I urge all of my colleagues to join me as cosponsors of this legislation. Thank you, Mr. Speaker, I yield back the balance of my time.

INTRODUCTION OF THE MEDICARE MARKET ACQUISITION DRUG PRICE ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 2003

Mr. STARK. Mr. Speaker, I rise today to introduce the Medicare Market Acquisition Drug Price Act. This bill would correct a long-standing and well-documented problem with the way Medicare pays for the few outpatient prescription drugs it covers today. This bill would save the government billions of dollars and lower cost-sharing for Medicare beneficiaries who are paying a substantial share of the industry's bloated prices today. Congress should enact this bill immediately.

This problem must be resolved—this year—whether or not we succeed in creating a new Medicare prescription drug benefit. We have had hearings, we have had GAO and Inspector General reports, and we have had bipartisan consensus that this is a problem, but due to pharmaceutical industry efforts, we have had no congressional action. This problem was not addressed in the prescription drug legislation passed by the House Republican leadership last Congress. In the absence of congressional action, the Centers for Medicare and Medicaid Services, CMS, at the Department of Health and Human Services recently took modest steps to trim overpayments resulting from the current system. I applaud

CMS's efforts and urge them to take any actions within their authority to ensure that Medicare pays reasonable prices for drugs.

However, the ultimate solution to this problem requires legislation. Despite the House Republican leadership's persistent neglect of the issue, I believe there is bipartisan consensus that Medicare should not continue to pay exorbitant prices for prescription drugs. I urge my colleagues to join me in supporting this bill.

Medicare currently pays for only a limited number of outpatient drugs, generally ones that a patient cannot self-administer, such as chemotherapy drugs. Medicare spends over $5 billion every year on these drugs. Under current rules, Medicare vastly over-pays for these drugs, because it bases payments on the artificially high ''average wholesale price,'' AWP, reported by the drug's manufacturer—regardless of the actual price a provider pays for the drug. There is abundant evidence that drug manufacturers have boosted their own drug sales and increased their profits, at great taxpayer expense, by manipulating the AWP of their drugs. Simply put, drug manufacturers report inflated prices, sell providers the drugs for much less, and then encourage providers to bill Medicare for the maximum allowable amount—95 percent of the inflated AWP reported by the manufacturer.

This bill offers a straightforward solution to this problem. It would require Medicare payments to be based on the actual market prices at which manufacturers sell their drugs. This price, called the average acquisition price, would be verifiable. The Secretary would have the authority to audit drug companies' reports. Drug companies would be subject to steep fines for deliberately filing false or incomplete information.

Mr. Speaker, the current Medicare AWP rules are a sham and must be changed. Consider the following:

The General Accounting Office has described the AWT as ''neither 'average' nor 'wholesale;' it is simply a number assigned by the product's manufacturer.'' The GAO found that Medicare's payments for physician-administered outpatient drugs were at least $532 million higher than providers' potential acquisition costs in 2000. Similarly, the GAO found that Medicare paid at least $483 million more for supplier-billed drugs than suppliers' potential acquisition costs in 2000. Some drugs were available at prices averaging less than 15 percent of the manufacturer's reported AWP, while Medicare continued to pay 95 percent of AWP.

In a real-life example, Mr. Bob Harper of Florida wrote to me about the high costs of one of his wife's chemotherapy drugs, Leucovorin. According to a September 2001 GAO report, this drug is widely available for just 14.4 percent of the AWP. Yet beneficiaries can be charged as much as 19 percent of the AWP—more than the actual price of the drug. Mr. Harper stated that his wife is being charged a co-payment of $155.27 for 36 treatments, or a total out-of-pocket charge of $5,589.72 for this drug. As Mr. Harper said, ''This is outrageous!''

The Office of the Inspector General, OIG, at the Department of Health and Human Services found that Medicare could save $761 million per year by paying the actual wholesale prices available to physicians and suppliers for just 24 of the outpatient drugs currently covered by Medicare.

Numerous states, consumer groups, and private health plans have sued drug manufacturers for fraudulently inflating Medicare drug prices.

These suits follow on the heels of a record Medicare and Medicaid fraud settlement by TAP Pharmaceutical Products. In October 2001, TAP pleaded guilty to a charge of conspiracy to violate federal law. TAP agreed to pay $875 million—the largest criminal fine ever levied by the government for health care fraud—to settle the suit, in which the government alleged the company artificially inflated the AWP of the company's prostate cancer drug Lupron.

In October 2002, the OIG issued draft compliance program guidance to pharmaceutical companies. This guidance specifically highlighted pharmaceutical companies' manipulation of the average wholesale price as fraudulent behavior: ''A pharmaceutical manufacturer's purposeful manipulation of the AWP to increase its customers' profits by increasing the amount the Federal health care programs reimburse its customers implicates the anti-kickback statute.''

Mr. Speaker, the problem is well known. The solution is straightforward. Both the GAO and the OIG have recommended that we revise Medicare's drug payment policies to reflect actual market prices, accounting for rebates and other discounts available from manufacturers. That is exactly what this bill does.

Manufacturers would be required to report the actual average market acquisition prices for their drugs as a condition for Medicare coverage of those drugs. Each manufacturer would have to certify the accuracy of its reports and the Secretary of HHS would be empowered to audit price information to verify the accuracy of the reports. Drug manufacturers would be subject to unlimited civil monetary penalties for filing false reports and would be subject to a penalty of $100,000 for each day they fail to provide timely information.

The bill is also carefully crafted to ensure that the reimbursement revisions will not adversely impact Medicare beneficiaries' access to care. First, to ensure these drugs are available in areas of the country where providers must purchase covered drugs at prices above the average, the actual reimbursement level to providers would be set 5 percent above the average acquisition price. Second, Medicare would pay dispensing fees to reflect differences in the costs of dispensing different drugs and biologics. Third, the bill would ensure continued access to cancer treatment. Oncologists have argued that inflated AWP reimbursements are necessary to compensate for the administration of cancer medicines. This bill would correct this anomaly by revising Medicare payments for oncology services to appropriately account for these indirect costs, in accordance with GAO recommendations.

Mr. Speaker, I sincerely hope that Congress will act to provide a meaningful Medicare prescription drug benefit this year. On top of the many other serious concerns I have with the so-called drug benefit bills offered by the Republican leadership in recent years, I am deeply disappointed that they have not addressed the abuses of the current AWP system. We must not shirk our responsibility to ensure that Medicare properly pays for the limited outpatient prescription drugs it already covers. There is no need for taxpayers to continue to fill pharmaceutical companies' coffers with the ill-gotten gains of the current AWP system. I hope all of my colleagues will join me in passing this important legislation.

PASS 21ST CENTURY WATER COMMISSION ACT

HON. JOHN LINDER

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 7, 2003

Mr. LINDER. Mr. Speaker, over the past year, major newspapers reported almost daily on water problems, as over half of the United States experienced drought conditions. Rivers and wells dried up, aquifers were challenged by saltwater intrusion, and fish, wildlife, and crops were threatened. In many states, the droughts continue today, with no relief in sight. Even without the problems caused by drought, projected population growth for the United States indicates that water demand will continue to increase in coming years. It is critical that states across the nation find ways to store more fresh water to meet growing needs.

Water resources managers will be faced with unavoidable, life-threatening challenges in the 21st century, and we must prepare for these challenges now through extensive research and coordination of objectives among all levels of water management—federal, state, local, and the private sector. I am introducing a bill today to begin this process.

My bill would create the ''21st Century Water Commission'' to recommend strategies for meeting 21st century water challenges. The commission, composed of seven members appointed by the President, is charged with assessing future water supply and demand, evaluating federal water programs and the coordination of federal agencies, and researching contemporary technologies for increasing fresh water resources. The commission would also make recommendations for conserving fresh water, storing excess water for use in times of drought, and repairing aging, leaky infrastructures.

The legislation I am introducing today is designed to bring our nation's premier water experts and managers together to the discussion table to share their ideas for the future. This bill is in no way intended to federalize our nation's water policies; it should create a resource and a research engine to enable local communities to better solve their water problems.

In John Steinbeck's novel, East of Eden, the narrator observes, ''It never failed that during the dry years the people forgot about the rich years, and during the wet years they lost all memory of the dry years. It was always that way.'' I have been told over and over again that the United States only reevaluates its water policies when a crisis hits. But failure to plan for future water shortages is a recipe for disaster. We must begin now to advance the science and knowledge that will be necessary to deal with 21st century water challenges.

Last March, EPA Administrator Christie Whitman expressed that, ''Water is going to be the biggest environmental issue that we face in the 21st century, in terms of both quantity and quality.'' I couldn't agree more. Mr. Speaker, we must begin working today to meet this challenge, by passing the ''21st Century Water Commission Act.''