

AMENDMENT NO. 2000

At the request of Mr. NELSON of Florida, the names of the Senator from Nebraska (Mr. HAGEL), the Senator from South Dakota (Mr. JOHNSON), the Senator from Maryland (Ms. MIKULSKI), the Senator from Arkansas (Mrs. LINCOLN), the Senator from California (Mrs. BOXER) and the Senator from Colorado (Mr. SALAZAR) were added as cosponsors of amendment No. 2000 intended to be proposed to H.R. 1585, to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SPECTER (for himself and Mr. CASEY):

S. 1750. A bill to amend title XVIII of the Social Security Act to preserve access to community cancer care by Medicare beneficiaries; to the Committee on Finance.

Mr. SPECTER. Mr. President, I have sought recognition today to introduce the Community Cancer Care Preservation Act, which will ensure Medicare beneficiaries' access to community-based cancer treatment and provide Medicare reimbursement assistance for oncologists providing vital cancer care services.

Cancer takes a great toll on our friends, family and our Nation. In the U.S. cancer causes one out of every four deaths. Although the number of cancer diagnoses appears to have plateaued, more than 1.4 million Americans will still find out they have a form of cancer in 2007, and 560,000 will die, keeping cancer the second-leading cause of death in the U.S. In 2005, over 2 million new cases of cancer were diagnosed, the most prevalent of which were breast, prostate, lung, and colorectal.

While these statistics are daunting, according to the American Cancer Society, the number of Americans who died of cancer in 2006 dropped for a second straight year. This decrease is the result of earlier detection and diagnosis, more effective and targeted cancer therapies, and greater accessibility to quality care provided by oncologists. These vital services have allowed millions of individuals to lead healthy and productive lives after successfully battling cancer.

In 2006, 43.2 million individuals were enrolled in Medicare; of those beneficiaries over 29 percent have had cancer during their lives, 12.5 million beneficiaries. With such a large percentage of our seniors facing this horrible disease, the need for access to community cancer care is critical.

Community cancer clinics treat 84 percent of Americans with cancer. Community cancer centers are free-standing outpatient facilities that pro-

vide comprehensive cancer care in a physician's office setting and are located in patients' communities. These clinics are especially critical in rural areas where access to larger cancer clinics may not be available. They provide patients with early diagnoses, effective cancer therapies, and innovative and supportive care that reduces fatigue, nausea/vomiting, and pain. The accessibility of treatment in the hands of skilled community oncologists has decreased the cancer mortality rate.

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, MMA, was signed into law by President Bush. This legislation contained numerous provisions that were beneficial to America's seniors and medical facilities; however, it also provided a reduction in Medicare's reimbursement for oncology treatment. The provisions sought to bring a balance to the reimbursement for the cost of cancer drugs and services. Prior to the implementation of the law, the Centers for Medicare & Medicaid Services, CMS, reimbursed the cost of cancer treatment drugs at a very high level. This level provided sufficient funding to supplement the costs of care and the storage of the prescription drugs, which were not being provided adequate reimbursement. The law enacted reimbursement reductions for the cost of prescription drugs while increasing the funding provided for cancer care services; however, that increase did not sufficiently offset oncologists' losses from the reduction in cancer drug reimbursement.

The Congressional Budget Office estimated that Medicare reimbursements to oncologists would be reduced by \$4.2 billion from 2004–2013. PricewaterhouseCoopers, an independent auditing firm, estimates that reductions will reach \$14.7 billion over that time. This increased reduction will have a debilitating effect on oncologists' ability to provide cancer treatment to Medicare beneficiaries, especially those in the community setting.

For 2005, CMS provided an estimated \$300 million in Medicare funding to community cancer clinics via a demonstration project, in part as stop-gap funding for Medicare reimbursement cuts. This funding was reduced to \$150 million in 2006 and has been eliminated in 2007. These decreases, in addition to other reductions in services payments, have resulted in a \$200–300 million reduction in reimbursement in 2007. However, this reimbursement reduction may be larger than estimated. CMS did not factor in the delay in the adjustment of reimbursement rates when a drug manufacturer increases the price for cancer therapies and the inability of some beneficiaries to pay their Medicare 20 percent coinsurance payment. When accounting for these reductions, the overall cut to cancer care will likely exceed \$300–400 million.

The MMA mandated a transitional increase of 32 percent in service fees in

2004, falling to 3 percent in 2005, and 0 percent in 2006. This was done to provide time for CMS to pay for essential unpaid medical services, such as pharmacy facilities and treatment planning. In 2005, CMS created a cancer care demonstration project as a quality enhancement initiative to examine the effects of oncology drugs on patients. This demonstration project also provided \$300 million in critical funding because CMS had not increased the reimbursement for essential unpaid medical services. On June 29, 2005, I sent a letter with 38 other Senators to President Bush requesting an extension of the demonstration project through 2006. CMS, however, announced a new oncology demonstration project for 2006 that examines the quality of cancer care in relation to treatment guidelines, but at least \$150 million less than the previous funding level.

Accordingly, I am introducing legislation to provide assistance to community oncologists that are disadvantaged by CMS reforms brought forth under the MMA. The bill's \$1.7 billion cost, over the next 5 years, is a relatively small cost in the face of the vast reductions in CMS's reimbursement to oncologists. Let me briefly summarize the provisions of this legislation.

1. Sales Price Updates: Currently, CMS updates the prices for cancer treatment drugs quarterly, however there is a 6-month lag from when prices increase in the marketplace and when CMS applies that information to increase reimbursement. For example, a price change in the first quarter will not be reflected until reimbursement in the third quarter. This forces community cancer clinics to often pay increased prices for prescription drugs without increased reimbursement. This legislation requires the sales price for oncology drug reimbursement be updated as changes occur in the price to provide a more accurate reimbursement to oncologists for the cost of drugs every 2 months. This will provide reimbursements to oncologists that are fair and reflective of market costs.

2. Removal of the Prompt Pay Discount: The prompt pay discount is a discount from the pharmaceutical manufacturer to the wholesaler, not the community cancer clinic, for prompt payment on prescription drugs. However, the MMA requires that this prompt pay discount be included in the calculation of average sales price, ASP, which forms the basis for the Medicare drug reimbursement provided, by the manufacturer. This has the impact of lowering ASP, thus artificially lowering drug reimbursement to community cancer clinics. My legislation would remove the prompt pay discount from ASP, requiring CMS to reimburse oncologists at the price they actually pay for drugs without the inclusion of discounts.

3. Increase in Payments for Chemotherapy Administration: The MMA increased the payment for the first hour

of chemotherapy administration by 32 percent on a transitional basis in 2004. The intent of this was to provide an increase in payment for cancer care services that were under-reimbursed but subsidized by overpayments for cancer drugs under the previous system. While the MMA attempted to balance the payment for both drugs and services, including increasing payments to cover the increasing costs of delivering quality cancer care, the 32 percent was temporary and expired at the end of 2004. This legislation re-establishes 2004 levels of reimbursement.

Further, cancer patients can receive multiple hours of chemotherapy and must be constantly monitored by skilled oncology nurses. Payment for the cost of providing quality cancer care must ensure patient safety during the process of administering often toxic medications, which can produce life-threatening side effects. To meet this need, this bill also provides an increase in funding for the subsequent hours of chemotherapy administration at 70 percent of the first hour payment rate.

4. Payments for Oncological Drug Storage: CMS reimbursement for oncology prescription drugs does not provide adequate funding for storage and care needs. The prescription drugs for cancer care often require refrigeration and specialized handling, as some drugs are highly toxic. These special provisions result in an increased cost, which is why my legislation provides a 2 percent increase in drug reimbursement to account for the storage and care of oncology drugs.

5. Oncology Treatment Planning: Oncology treatment planning provides a personalized treatment program for oncology patients. This legislation creates two payment codes for treatment planning: moderate and complex. Radiation oncologists are currently reimbursed for treatment planning; however, medical oncologists, who provide the treatment plan foundation, are not reimbursed for treatment planning.

As both chairman and ranking member of the Labor, Health and Human Services, and Education Appropriations Subcommittee, I have sought to increase funding for the National Institutes of Health, and the National Cancer Institute, NCI. Since becoming chairman of the LHHS Subcommittee, the funding for NIH has increased from \$11.3 billion in fiscal year 1996 to \$29 billion in 2007, an increase of 157 percent, while funding for the NCI increased from \$2.3 billion in fiscal year 1996 to \$4.8 billion in 2007, an increase of 109 percent.

In 1970, President Nixon declared war on cancer. Had that war been prosecuted with the same diligence as other wars, my former chief of staff, Carey Lackman, a beautiful young lady of 48, would not have died of breast cancer. One of my very best friends, a very distinguished Federal judge, Chief Judge Edward R. Becker, would not have died of prostate cancer. All of us know peo-

ple who have been stricken by cancer, who have been incapacitated with Parkinson's or Alzheimer's, who have been victims of heart disease, or many other maladies.

I sustained an episode with Hodgkin's lymphoma cancer 2 years ago. That trauma, that illness, I think, could have been prevented had that war on cancer declared by the President of the United States in 1970 been prosecuted with sufficient intensity.

This legislation provides Medicare reimbursement assistance for community oncologists and ensures Medicare beneficiaries' access to community-based cancer treatment. I encourage my colleagues to work with Senator CASEY and me to move this legislation forward promptly.

By Mr. HARKIN (for himself and Mr. SMITH):

S. 1753. A bill to amend the Internal Revenue Code of 1986 to provide a tax credit to employers for the costs of implementing wellness programs, and for other purposes; to the Committee on Finance.

Mr. HARKIN. Mr. President, today, culminating many months of consultation with health experts and business, Senator GORDON SMITH and I will introduce the Healthy Workforce Act.

The aim of this bill is to help American businesses to provide a whole range of opportunities for their employees to live healthier lives. The idea is to make it easier for businesses to push more of their health care investments upstream, helping their employees to get healthy and stay healthy, and to stay out of the hospital.

Corporate America traditionally has not been a major player in the field of wellness and disease prevention. But that is rapidly changing as you can tell by the presence of these important business leaders, here, this morning. This is extremely encouraging. Because corporate America has the expertise, the resources, and the enlightened self-interest to make a huge difference in the way we approach health care in this country.

So, in introducing this bill, Senator SMITH and I are making something of a business proposition, a proposal for a partnership. We believe that the Federal Government needs to provide incentives in the form of tax credits and, in return, we want corporate America to step more boldly into the field of wellness and disease prevention.

Here is what the Healthy Workforce Act would do. It would give a 50-percent tax credit to businesses that offer a qualified comprehensive wellness program to their employees. For a company to receive the 50-percent credit, the employee wellness program must include three of the following four components:

First, a health awareness and education component, which could include health risk assessments and screenings.

Second, a behavioral change component, for instance: counseling, semi-

nars, or self-help materials to help employees to lead healthier lifestyles.

Third, a supportive environment component. This might include offering meaningful incentives to participating employees, for example, a reduction in health premiums, or allowing employees to exercise during the workday.

And fourth, creation of an employee engagement committee, which would tailor the wellness program to the needs of the workforce at a particular company.

I am pleased that the Healthy Workforce Act already has the support of the American Heart Association, the Coalition on Catastrophic and Chronic Health Care Costs, and a whole range of other public health groups and others in the business community.

As I said, employee wellness is a matter of enlightened corporate self-interest. Employees who are fit are less likely to call in sick. They have more energy and self-confidence. They are more resistant to stress. They have better attitudes. Obviously, corporate America also has a profound interest in keeping down health insurance costs.

But businesses can't get this job done alone. It is high time for the Federal Government to step up to the plate in a very robust way. And that is exactly what the Healthy Workforce Act is all about.

In conclusion, I just want to emphasize, again, that this bill is the product of a pretty amazing collaboration. There is tremendous expertise and good will in both the business community and in the public health community. Their ideas and input have made this a better bill. And I deeply appreciate their assistance. I look forward to continuing this partnership and working to pass this critically needed legislation.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 263—TO AUTHORIZE TESTIMONY AND LEGAL REPRESENTATION IN STATE OF IOWA V. CHESTER GUINN, BRIAN DAVID TERRELL, DIXIE JENNESS WEBB, KATHLEEN MCQUILLEN, AND ELTON LLOYD DAVIS

Mr. REID (for himself and Mr. MCCONNELL) submitted the following resolution; which was considered and agreed to:

S. RES. 263

Whereas, in the cases of State of Iowa v. Chester Guinn (SMAC288541), Brian David Terrell (SMAC288544), Dixie Jenness Webb (SMAC288545), Kathleen McQuillen (SMAC288543), and Elton Lloyd Davis (SMAC288539), pending in Iowa District Court for Polk County in Des Moines, Iowa, testimony has been requested from Robert Renaud and Janice Goode, employees in the office of Senator Chuck Grassley;

Whereas, pursuant to sections 703(a) and 704(a)(2) of the Ethics in Government Act of 1978, 2 U.S.C. §§288b(a) and 288c(a)(2), the