TIME TO EXPAND AMERICAN ENERGY EXPLORATION

(Mr. SMITH of Nebraska asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Nebraska. Mr. Speaker, American families are preparing for the holiday season and doing so by paying the highest fuel prices in 2 years.

In addition to gasoline, heating oil and diesel prices are expected to increase year over year for the first time since 2008, and analysts are predicting oil will hit $100 a barrel very soon. At a time when our economy is struggling to recover, such skyrocketing energy prices could be catastrophic.

This is why it makes no sense the administration recently announced plans to cancel further energy exploration and development in deep offshore areas. These sources of American energy are known to contain more than 86 billion barrels of recoverable oil.

This decision to prevent energy development hurts our economy and costs American jobs. Let's give Americans what they deserve. The time is now to expand exploration of American energy resources.

STOP SHOOTING CHILDREN

(Mr. BAIRD asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BAIRD. My colleagues, it is time to call on our allies in the State of Israel to stop shooting children.

Since March of this year, 17 children have been shot by Israeli snipers near the border of Gaza, shot for the crime of picking up small pieces of rock to use for aggregate because the Israeli blockade is preventing construction materials from coming into Gaza. Seventy percent of these children were shot while doing this activity beyond the 300-meter unilaterally imposed security zone. Young children and adults are picking up small pieces of gravel because they cannot import concrete to rebuild schools, hospitals, clinics and water treatment facilities without it.

Let us call upon our allies in the State of Israel to stop shooting children, to prosecute those who have shot children, and to lift the blockade to allow raw materials in and economic prosperity to succeed.

On this Human Rights Day it's the least we can do.

□ 1010

SUPPLY AND DEMAND

(Mr. THOMPSON of Pennsylvania asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. THOMPSON of Pennsylvania. Mr. Speaker, a recent headline in the Atlanta Journal-Constitution talked about the scarcity of heating fuel, which sent prices through the roof. By contrast, the Philadelphia Inquirer reported on a drop in utility bills in the area due to Marcellus Shale drilling in Pennsylvania. Both are classic examples of such supply and demand.

Heating fuel in Atlanta is fed, in great part, by the production of offshore oil and natural gas reserves from the Gulf of Mexico. Unfortunately, last week vast amounts of our own oil and natural gas reserves off the Atlantic and Pacific coast were placed off limits by the White House, limiting production and, as a result, supply.

Secretary of the Interior Salazar, through regulation, not legislation, removed nearly all of our vast offshore oil and natural gas reserves from the production process. The result, not one barrel of oil or cubic foot of natural gas owned by other citizens will be produced until at least 2022.

In Pennsylvania, recent development of Marcellus Shale natural gas has brought the opposite effect. A lower rate from the Philadelphia Gas Works will save the average customer almost $15 per month.

The solution is obvious, and Congress should reclaim its jurisdiction over our energy future.

THE DREAM ACT

(Mr. SCHIFF asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SCHIFF. Mr. Speaker, for the past three Congresses, I've been an enthusiastic cosponsor of the DREAM Act, which I see as an essential component of comprehensive immigration reform.

No child raised in America should be permanently penalized for the immigration status of their parents. The DREAM Act gives young people a chance to contribute to the United States, often the only country they know. I've heard from many high school students in my district who have done everything right, but discover when they apply to college that they are not a citizen, that the doors of education and a better life they have worked for so hard are closed to them.

The U.S. has a proud tradition of welcoming immigrants who want to work hard and play by the rules and build a better life for themselves and their families. The DREAM Act comes from that tradition. It will make our economy, military, and Nation stronger.

Yesterday evening I was proud to cast an ''aye'' vote on the rule to bring the DREAM Act to the floor. I was not on the floor later that night and missed the final vote on the act. Had I been present, I would have enthusiastically voted ''aye,'' and I urge my Senate colleagues to take up the legislation in the remaining days of the 111th Congress.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. ALTMIRE). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

MEDICARE AND MEDICAID EXTENDERS ACT OF 2010

Mr. STARK. Mr. Speaker, I move to suspend the rules and concur in the Senate amendments to the bill (H.R. 4994) to amend the Internal Revenue Code of 1986 to reduce taxpayer burdens and enhance taxpayer protections, and for other purposes.

The Clerk read the title of the bill.

The text of the Senate amendments is as follows:

Senate amendments:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare and Medicaid Extenders Act of 2010''.

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

TITLE I—EXTENSIONS

SEC. 101. PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(12) UPDATE FOR 2011.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), and (11)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2011, the update to the single conversion factor shall be 0 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2012 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2012 and subsequent years as if subparagraph (A) had never applied.''.

SEC. 102. EXTENSION OF MMA SECTION 508 RECLASSIFICATIONS.

(a) EXTENSION.—

(1) IN GENERAL.—Section 106(a) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), and sections 3137(a) and 10317 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by striking ''September 30, 2010'' and inserting ''September 30, 2011''.

(2) SPECIAL RULE FOR FISCAL YEAR 2011.—

(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1), including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2011, the Secretary of Health and Human Services shall use the hospital wage index that was promulgated by the Secretary of Health and Human Services in the Federal Register on August 16, 2010 (75 Fed. Reg. 50042), and any subsequent corrections.

(B) EXCEPTION.—Beginning on April 1, 2011, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable reclassified wage index. Any revision to hospital wage indexes made as a result of this subparagraph shall not be effected in a budget neutral manner.

(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2011.—

(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

(ii) the wage index applicable for such hospital for the period beginning on October 1, 2010, and ending on March 31, 2011, was lower than for the period beginning on April 1, 2011, and ending on September 30, 2011, by reason of the application of paragraph (2)(B);

the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph (A) by not later than December 31, 2011.

(b) CONFORMING AMENDMENT.—Section 117(a)(3) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by inserting ''in fiscal years 2008 and 2009'' after ''For purposes of implementation of this subsection''.

SEC. 103. EXTENSION OF MEDICARE WORK GEOGRAPHIC ADJUSTMENT FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2011'' and inserting ''before January 1, 2012''.

SEC. 104. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking ''and ending on'' and all that follows through ''2010'' and inserting ''and ending on December 31, 2011''.

SEC. 105. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), and section 3104 of the Patient Protection and Affordable Care Act (Public Law 111–148) is amended by striking ''and 2010'' and inserting ''2010, and 2011''.

SEC. 106. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''2011'' and inserting ''2012,''; and

(2) in each of clauses (i) and (ii), by striking ''January 1, 2011'' and inserting ''January 1, 2012'' each place it appears.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), as amended by sections 3105(b) and 10311(b) of Public Law 111–148, is amended by striking ''December 31, 2010'' and inserting ''December 31, 2011''.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking ''2011'' and inserting ''2012''.

SEC. 107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON PAYMENT.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), as amended by section 3107 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by striking ''December 31, 2010'' and inserting ''December 31, 2011''.

SEC. 108. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)), as amended by section 3121(a) of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking ''2011''and inserting ''2012''; and

(B) in the second sentence, by striking ''or 2010'' and inserting ''2010, or 2011''; and

(2) in subclause (III), by striking ''January 1, 2011'' and inserting ''January 1, 2012''.

SEC. 109. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note), section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), and section 3122 of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by striking ''the 1-year period beginning on July 1, 2010'' and inserting ''the 2-year period beginning on July 1, 2010''.

SEC. 110. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking ''December 2010'' and inserting ''December 2011''.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of such Act (42 U.S.C. 1396u-3(g)) is amended—

(1) in paragraph (2)—

(A) by striking ''and'' at the end of subparagraph (M);

(B) in subparagraph (N), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new subparagraphs:

''(O) for the period that begins on January 1, 2011, and ends on September 30, 2011, the total allocation amount is $720,000,000; and

''(P) for the period that begins on October 1, 2011, and ends on December 31, 2011, the total allocation amount is $280,000,000.''; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking ''or (N)'' and inserting ''(N), or (P)''.

SEC. 111. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''December 31, 2010'' and inserting ''December 31, 2011''.

SEC. 112. SPECIAL DIABETES PROGRAMS.

(1) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2011'' and inserting ''2013''.

(2) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2011'' and inserting ''2013''.

TITLE II—OTHER PROVISIONS

SEC. 201. CLARIFICATION OF EFFECTIVE DATE OF PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

Effective as if included in the enactment of Public Law 111–148, section 3110(a)(2) of such Act is amended to read as follows:

''(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made on and after the date of the enactment of this Act.''.

SEC. 202. REPEAL OF DELAY OF RUG–IV.

Effective as if included in the enactment of Public Law 111–148, section 10325 of such Act is repealed.

SEC. 203. CLARIFICATION FOR AFFILIATED HOSPITALS FOR DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

Effective as if included in the enactment of section 5503(a) of Public Law 111–148, section 1886(h)(8) of the Social Security Act (42 U.S.C. 1395ww(h)(8)), as added by such section 5503(a), is amended by adding at the end the following new subparagraph:

''(I) AFFILIATION.—The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.''.

SEC. 204. CONTINUED INCLUSION OF ORPHAN DRUGS IN DEFINITION OF COVERED OUTPATIENT DRUGS WITH RESPECT TO CHILDREN'S HOSPITALS UNDER THE 340B DRUG DISCOUNT PROGRAM.

(a) DEFINITION OF COVERED OUTPATIENT DRUG.—

(1) AMENDMENT.—Subsection (e) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended by striking ''covered entities described in subparagraph (M)'' and inserting ''covered entities described in subparagraph (M) (other than a children's hospital described in subparagraph (M))''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 2302 of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152).

(b) TECHNICAL AMENDMENT.—Subparagraph (B) of section 1927(a)(5) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)) is amended by striking ''and a children's hospital'' and all that follows through the end of the subparagraph and inserting a period.

SEC. 205. MEDICAID AND CHIP TECHNICAL CORRECTIONS.

(a) REPEAL OF EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking paragraph (78).

(b) INCOME LEVEL FOR CERTAIN CHILDREN UNDER MEDICAID.—Section 1902(l)(2)(C) of the Social Security Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking ''133 percent'' and inserting ''100 percent (or, beginning January 1, 2014, 133 percent)''.

(c) CALCULATION AND PUBLICATION OF PAYMENT ERROR RATE MEASUREMENT FOR CERTAIN YEARS.—Section 601(b) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) is amended by adding at the end the following: ''The Secretary is not required under this subsection to calculate or publish a national or a State-specific error rate for fiscal year 2009 or fiscal year 2010.''.

(d) CORRECTIONS TO EXCEPTIONS TO EXCLUSION OF CHILDREN OF CERTAIN EMPLOYEES.—Section 2110(b)(6) of the Social Security Act (42 U.S.C. 1397jj(b)(6)) is amended—

(1) in subparagraph (B)—

(A) by striking ''PER PERSON'' in the heading; and

(B) by striking ''each employee'' and inserting ''employees''; and

(2) in subparagraph (C), by striking '', on a case-by-case basis,''.

(e) ELECTRONIC HEALTH RECORDS.—Effective as if included in the enactment of section 4201(a)(2) of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), section 1903(t) of the Social Security Act (42 U.S.C. 1396b(t)) is amended—

(1) in paragraph (3)(E), by striking ''reduced by any payment that is made to such Medicaid provider from any other source (other than under this subsection or by a State or local government)'' and inserting ''reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government)''; and

(2) in paragraph (6)(B), by inserting before the period the following: ''and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost''.

(f) CORRECTIONS OF DESIGNATIONS.—

(1) Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10), in the matter following subparagraph (G), by striking ''and'' before ''(XVI) the medical'' and by striking ''(XVI) if'' and inserting ''(XVII) if'';

(B) in subsection (a)(23), by striking ''(ii)'' and inserting ''(kk)'';

(C) in subsection (a)(77), by striking ''(ii)'' and inserting ''(kk)'';

(D) in subsection (ii)(2), as added by section 2303(a)(2) of Public Law 111–148, by striking ''(XV)'' and inserting ''(XVI)''; and

(E) by redesignating subsection (ii), as added by section 6401(b)(1)(B) of Public Law 111–148, as subsection (kk) and transferring such subsection so as to appear after subsection (jj) of that section.

(2) Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) in subparagraph (D), as added by section 6401(c) of Public Law 111–148, by striking ''(ii)'' and inserting ''(kk)''; and

(B) by redesignating the subparagraph (N) of that section added by 2101(e) of Public Law 111–148 as subparagraph (O).

SEC. 206. FUNDING FOR CLAIMS REPROCESSING.

For purposes of carrying out the provisions of, and amendments made by, this Act that relate to title XVIII of the Social Security Act, and other provisions of, or relating to, such title that ensure appropriate payment of claims, there are appropriated to the Secretary of Health and Human Services for the Centers for Medicare & Medicaid Services Program Management Account, from amounts in the general fund of the Treasury not otherwise appropriated, $200,000,000. Amounts appropriated under the preceding sentence shall be in addition to any other funds available for such purposes, shall remain available until expended, and shall not be used to implement changes to title XVIII of the Social Security Act made by Public Laws 111–148 and 111–152.

SEC. 207. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(B) of the Social Security Act (42 U.S.C. 1395iii(b)(1)(B)) is amended by striking ''$550,000,000'' and inserting ''$275,000,000''.

SEC. 208. LIMITATIONS ON AGGREGATE AMOUNT RECOVERED ON RECONCILIATION OF THE HEALTH INSURANCE TAX CREDIT AND THE ADVANCE OF THAT CREDIT.

(a) IN GENERAL.—So much of section 36B(f)(2)(B) of the Internal Revenue Code of 1986 as precedes clause (ii) thereof is amended to read as follows:

''(B) LIMITATION ON INCREASE.—

''(i) IN GENERAL.—In the case of a taxpayer whose household income is less than 500 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

''If the household income (expressed as a percent of poverty line) is:	*The applicable dollar amount is:*
Less than 200%	*$600*
At least 200% but less than 250%	*$1,000*
At least 250% but less than 300%	*$1,500*
At least 300% but less than 350%	*$2,000*
At least 350% but less than 400%	*$2,500*
At least 400% but less than 450%	*$3,000*
At least 450% but less than 500%	*$3,500''.*

(b) CONFORMING AMENDMENT.—Section 36B(f)(2)(B)(ii) of such Code is amended by inserting ''in the table contained'' after ''each of the dollar amounts''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 209. DETERMINATION OF BUDGETARY EFFECTS.

(a) IN GENERAL.—The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled ''Budgetary Effects of PAYGO Legislation'' for this Act, submitted for printing in the Congressional Record by the Chairman of the Senate Budget Committee, provided that such statement has been submitted prior to the vote on passage.

(b) EMERGENCY DESIGNATION FOR CONGRESSIONAL ENFORCEMENT.—In the House of Representatives, this Act, with the exception of section 101, is designated as an emergency for purposes of pay-as-you-go principles.

Amend the title so as to read: ''An Act to extend certain expiring provisions of the Medicare and Medicaid programs, and for other purposes.''.

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

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

Mr. STARK. Mr. Speaker, I rise in support of H.R. 4994, the Medicare and Medicaid Extenders Act, a bill that was passed by unanimous consent in the Senate yesterday because of the critical importance to our senior citizens and military families.

The legislation does the bare minimum of what is needed to ensure that Medicare runs smoothly for the next year. Because the military's TRICARE system operates by many of Medicare's rules, it also protects the health care of our military families.

Importantly, the bill prevents a nearly 25 percent pay cut to Medicare and TRICARE physicians that would otherwise go into effect on January 1, 2011. Giving physicians a year of certainty in their pay is important to protect Medicare beneficiaries' access to their physicians. The bill extends a host of other key policies to protect the health of seniors and people with disabilities.

In the long run, we all know we need to do much better by Medicare than continued 1-year patches on the physician payment formula. The House passed a permanent solution in November of 2009, but the Senate was unable to move it. We need to work together across party lines to reach a permanent solution. In the meantime, H.R. 4994 is the appropriate short-term measure.

I urge my colleagues to join us in protecting the Medicare beneficiaries by voting ''yes.''

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

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

When the Democrats passed their massive health care overhaul, they didn't spend one cent to resolve a long-standing problem and ensure seniors have continued access to their physician. As a result, for the fourth time since Obamacare passed, we are forced to take emergency action to prevent physicians from having their Medicare payments slashed. This time, the looming cut is 25 percent. The brinkmanship where this Democrat Congress has walked physicians up to the cliff, only to back away at the last minute, is unacceptable.

My friends on the other side of the aisle are quick to remind us that they

offered to address Medicare physician payments last fall. This is true. They put a bill on the floor which had already failed to pass the Senate. This bill would have expanded our already record deficit by an astounding $210 billion, a crippling debt load on top of the $1 trillion health bill. Rather than responsibly manage the Medicare program, they chose instead to cut Medicare by one half trillion dollars to fund their government takeover of health care.

The good news is that today we are finally starting to address this problem in a bipartisan way. We're stopping these cuts not for 1 month or 2 months but for a full year. We're ensuring that physicians will be able to keep their doors open and that seniors will have continued access to their doctors. And we are doing this in a fiscally responsible manner without adding a dime to the deficit. We are doing it by taking aim at the irresponsible overspending that was created by the new health care law.

Let it be known on this day, in the people's House, that dismantling of Obamacare begins. Once the House passes this bill and the President signs it into law, we will have landed the first blow to the Democrats' massive health care overhaul. Today we begin by removing $19 billion from their risky $1 trillion experiment; a risky experiment that CBO predicts will force health insurance premiums for millions of families to increase by $2,100 in 2016 alone; a risky experiment that the Obama administration predicts could force 117 million Americans out of their health plans; a risky experiment that Medicare officials have repeatedly warned could jeopardize seniors' access to care; a risky experiment that Medicare officials predict will force millions of seniors out of their current Medicare and retiree health coverage; a risky experiment that increases taxes by more than one-half trillion dollars at a time when unemployment is nearly 10 percent.

□ 1020

A risky experiment that would spend an additional $1 trillion on health care when every respective economist tells us in order to improve our country's fiscal health, we must get control of health care spending.

My friends on the other side of the aisle repeatedly said a doctor's fix couldn't be paid for, that it shouldn't be paid for. Yet with bipartisan work, we have before us a fully offset bill that gives physicians 1 year of certainty while Congress works to reform physician payments in a fiscally responsible manner once and for all.

So here we are today, Mr. Speaker, pulling at the thread that will begin to unravel ObamaCare. Rest assured, America, we are taking $19 billion today, but we will continue to fight to get the rest next year.

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

GENERAL LEAVE

Mr. STARK. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on this matter.

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

There was no objection.

Mr. STARK. I would like to remind my distinguished friend that health reform was 100 percent paid for, and the party that wants to spend $700 billion on the richest Americans for their tax cuts certainly shouldn't lecture anyone on the deficit.

Mr. Speaker, I yield such time as he may consume to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, first of all let me say, as I did the other day, as you know, about a week ago we passed an extension to eliminate the cut in the SGR, the doctor's fix, until the end of this month. This bill before us today would take this for another year, until the end of December of 2011.

And at the time, the gentleman from California (Mr. HERGER) also got on the floor and made statements which I think totally do not represent what we were doing. First of all, I would say with regard to the doctor's fix, nobody wants a 25 percent cut in doctor's reimbursement rate, and that is why we were here last week for the extension to eliminate that cut until the end of this year, and that is why we are today, to eliminate that cut until the end of 2011.

But the fact of the matter is it is the Republican Party and it is the party of the gentleman from California (Mr. HERGER) in the House that refused to vote for a permanent fix when we passed it in the Democratic majority over a year ago. As I said that day, only one person, Dr. BURGESS who is a physician on our committee, voted with the Democrats for the permanent fix. It is as a result of the inability and the unwillingness of the Republicans to do anything about this doctor's cut or reimbursement cut that we had to pass, I guess, five different short-term fixes.

Now granted today we are going to have a year extension, and I am certainly happy that the Republicans have agreed to a year extension, but they still have not come along to a permanent fix and they have not helped us in our efforts to achieve a permanent fix. So for the gentleman to suggest that somehow the Republicans have been helpful and they wanted to deal with this problem is, in my opinion, simply not accurate.

Now, let me dispel another thing. There is nothing in this bill that would in any way disrupt or repeal the health care reform, the landmark legislation that the Democrats passed again this year without any support from the other side of the aisle. If there was any remote suggestion that we were repealing or this was the beginning of the repeal, as the gentleman suggested, of the health care reform, not one Democrat would support that; and I certainly would not.

The fact of the matter is that the health care reform was fully paid for. And the fact of the matter is that it did not in any way affect Medicare beneficiaries. We actually improved benefits for Medicare beneficiaries in the health care reform. We basically filled up and eliminated the doughnut hole. We also provided more money for copays so seniors who are poor or lower income would not have to do copays for preventative care. And the list of additional benefits for Medicare beneficiaries under the larger health care reform goes on and on. I could list more.

So the suggestion that we somehow were cutting Medicare benefits is simply not true. The fact of the matter is that benefits were increased; the bill was paid for; and this bill today in no way takes away from that larger health care reform.

Now we have paid for the health care reform. We have paid for the doctor's fix for an additional year in this legislation by making sure that people who were going to get a subsidy and who didn't qualify would have to pay it back. That is the only change. That is the way it is paid for here today.

I just want to say, Mr. Speaker, this is a very important bill. It is a vital piece of legislation for America's seniors, persons with disabilities, and military families. Without this legislation, physician fees in Medicare and TRICARE would be reduced by 25 percent on January 1, just 3 weeks from now, and that kind of cut would threaten the ability of enrollees in Medicare and TRICARE to see their doctors. We can't allow that to happen.

As I mentioned before, we have passed some short-term fixes. This is another short-term fix. But, thankfully, it is at least for another year until we can work out a permanent solution. The Democrats already passed that permanent solution without Republican help; but, unfortunately, therefore, it did not become law and we will have to address it again.

The bill also provides help in 2011 to low-income Medicare beneficiaries in paying their part B premiums which are nearly $100 per month for many people. The legislation extends several important Medicare policies, including an exceptions process for therapy caps that allows Medicare beneficiaries to access medically needed therapy treatment. And it extends an important program that helps Medicaid beneficiaries work more hours without losing their Medicaid benefits.

It is completely paid for over 10 years. It moved through the Senate by unanimous consent. It is really not controversial at all, and so I urge Members of the House to vote ''yes'' on this bill that provides stability to the Medicare program.

Mr. HERGER. Mr. Speaker, I yield the balance of my time to the ranking

member of the Energy and Commerce Committee, the gentleman from Texas (Mr. BARTON).

The SPEAKER pro tempore. Without objection, the gentleman from Texas will control the time.

There was no objection.

Mr. BARTON of Texas. I thank the gentleman from California for his courtesy.

I would ask the Chair how much time I have remaining.

The SPEAKER pro tempore. The gentleman has 15 minutes remaining.

Mr. BARTON of Texas. May I ask the Chair how much time my friends on the majority have remaining?

The SPEAKER pro tempore. The gentleman from California (Mr. STARK) has 13 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield myself such time as I may consume.

The Republicans do rise in support of this 1-year fix for the reimbursement rate for physicians. Having said that, I think I was able to listen to some of what my distinguished subcommittee chairman of the Energy and Commerce Committee, Mr. PALLONE, was saying as I was waiting for the tram to come over here. It is time, Mr. Speaker, for Members on both sides of the aisle to put aside partisan politics and in the upcoming year or years, if it takes more than 1 year, sit down and let's really come up with a new formula to fix permanently how we pay our physicians.

The current formula is based on an index that is based on inflation; and under the score keeping, any year in which medical expenses go up more rapidly than the general inflation rate, I am simplifying the index but this is the basic part of it, you have to find savings in that particular year or there is a negative balance created in the physician reimbursement fund. The current system is not sustainable. It doesn't work. It doesn't reflect the practice of medicine. But because of our score keeping, we keep getting further and further behind and so each year the 1-year cut gets bigger and bigger. This year it would be 25 percent.

Now obviously when most of our physician community claims, and I think with justification, that they are not being adequately reimbursed for treating Medicare patients, you have the situation as you have in my district, and I am sure each of us can say in our own districts, in their districts, physicians are not taking Medicare patients. In my home county of Ellis County, the county seat is a community of about 30,000, Waxahachie, Texas. The mayor of Waxahachie is a personal friend of mine, and I have known him for over 20 years.

□ 1030

His existing doctor retired. He is on Medicare. He is over 65. He went to find a new doctor who would treat him, and he couldn't find a doctor. Here is the mayor of Waxahachie, Texas, who at least temporarily cannot find a Medicare doctor who will accept him as a patient. That doesn't make sense. You can have the best health care system in the world, and if you don't have the doctors to implement it, you don't have a health care system.

So it is my strong recommendation that Republicans—the current minority, soon to be majority—vote for this 1-year fix, knowing that it is really not a fix, that it is another kick-the-can, kick-the-problem down the road. But in this case, at least it is for a year.

In the upcoming Congress and when the majorities switch, I am going to be a member of the committee of primary jurisdiction, the Energy and Commerce Committee. It will be my strong recommendation to our new chairman, FRED UPTON of Michigan; to our new Speaker, Mr. BOEHNER of Ohio; and to our new majority leader, Mr. CANTOR of Virginia, that we sit down with our stakeholders and with our friends on the soon-to-be minority side of the aisle to come up with a system that adequately reflects the will of both parties, that also gets buy-in from the stakeholders and reflects the cost of practicing medicine as it is today.

I know it is going to be expensive. I know it is going to be difficult, but it will be possible, and I hope that we can do that. I would ask for a ''yes'' vote when it comes time to vote for this under the suspension calendar.

I reserve the balance of my time.

The SPEAKER pro tempore. Without objection, the gentleman from New Jersey will control the time.

There was no objection.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. FARR).

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

Mr. FARR. Thank you very much for yielding.

Mr. Speaker, I rise in support of this bill but with real dismay.

First, it is ludicrous that Congress continues to pass the SGR instead of to fix it once and for all. This bill, though necessary, doesn't fix what is broken, and we will just find ourselves back here again next year, trying to find a way forward. It is time to ''repeal and replace'' the doctor payment formula and to come up with something new.

Second, this bill contains special ''pork'' favors for certain Midwest Senators which will pay their doctors more than the doctors in other parts of the country—in particular, my State of California.

Section 103 of this bill provides an arbitrary ''floor'' for certain doctors' payments in Iowa and in other Midwest States that will boost their Medicare reimbursements, but this provision does not extend to all doctors in the United States. Iowa will get an additional $17 million in FY 2011, on top of regular Medicare reimbursements, which other States will not get. Over the 2-year cycle of FY 2010–2011, Iowa doctors will be reimbursed over $34 million because of this special ''floor'' in payments inserted by Senator GRASSLEY and by others in that body.

In a bill that is supposed to be ''clean'' and that is supposed to simply advance a moratorium on reductions in the sustained growth rate, section 103 is an abomination. It is plain unfair to doctors in other States.

My doctors in California and especially in my district have suffered for more than a decade under a misaligned doctor payment formula due to outdated geographic locality designations. Despite numerous government reports by the GAO and CMS and despite numerous times that the House has passed legislation to fix this problem, the Senate has refused to accept the fix in favor of tipping the scales in order to satisfy Senator GRASSLEY's whims.

If Congress really wants to do right by doctors, it needs to do right by all doctors. This bill does not do that.

Mr. BARTON of Texas. Mr. Speaker, I yield 3 minutes to a distinguished member of the Energy and Commerce Committee and of the Health Subcommittee, the current ranking member of the Oversight and Investigations Subcommittee, Dr. MICHAEL BURGESS of Lewisville, Texas.

Mr. BURGESS. I thank the gentleman, my ranking member, for yielding.

Mr. Speaker, this is an important bill that is going to be before us today. Ordinarily, I would not support something this large being done on a suspension calendar, but this truly is an emergency for our Nation's patients and for our Nation's physicians.

I support the passage of this bill. It does also give us some time in this body and in the other body to work on a permanent solution. There is plenty of blame to go around on both sides of the aisle and in both Houses of this Capitol as to why we are in this fix.

The fact is that it began back in 1998 with the Omnibus Budget Reconciliation Act. It was extended under the Republican watch for 12 years. Now we have had 4 years under the Democrats, and it has not been fixed. In fact, most of the doctors you talk to have just come through the worst year ever in trying to manage their practices.

Stop and think about it for a minute.

You've got a small medical practice of two, three, four, five doctors. They don't do all Medicare work—maybe it's only 5 or 10 percent of their actual book of business. But in April and in June, we asked the administrator of the Centers for Medicare and Medicaid Services to hold the checks for a few weeks until Congress could get back from a recess and take up yet another fix for this problem.

The practical effect of doing this was that we cut 10, 15 percent off of the operating budget for every small practice that did Medicare, that saw our Medicare patients in this country that we asked them to see. Most physician offices run very close to the margin

every month. The consequence of this was that they had to go out and borrow the money to meet cash flow in April and in June. I dare say most of those practices have not yet fully recovered from that insult to the cash flow that occurred.

So it is extremely important for us to pass a 1-year extension that gives them the stability to be able to plan, that gives patients the ability to be able to find doctors under the Medicare system and that gives physician offices the ability to plan for the future.

Now, during this year that comes up, we are obligated—both sides of the aisle and both Houses in this Capitol—to fix this problem. Shame on us if it continues after this fix has expired. There is the political will to do it. We have heard it this morning from both sides. I will commit myself to working with, yes, my side, with the other side of the aisle and with the other House in this Capitol to work on a permanent solution to this. It is out there. It depends on how we want it to look. It depends on where we are going to get the pay-fors.

One of the most egregious things in this health care bill that the President signed last March was, even though you took $500 billion out of the Medicare system, you used that to fund a new entitlement for the middle class in subsidies in the exchange. Not one dime—not one dime—was sequestered to pay down the problem that we have with the sustainable growth rate formula.

Here is the real bad news.

The Independent Payment Advisory Board is coming up in 2015, also part of the health care bill that was signed into law last March. Doctors now, perhaps, face double jeopardy from cuts in the sustainable growth rate formula and from cuts within the Independent Payment Advisory Board.

The time to fix it is now. It stretches out ahead of us for 12 months. We've got time to do it. Let's dedicate ourselves to getting this done for our Nation's seniors.

Mr. PALLONE. I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I think all that needs to be said has been said; so let me simply say that this is a problem that needs to be dealt with.

I compliment those who negotiated the 1-year fix. Hopefully, in the next Congress, we will work together—and I mean that seriously—in a bipartisan fashion to replace the existing formula with one that doesn't have to be updated and fixed in every session of Congress. Yet, for today, I would urge all of those in the current minority to vote for the bill under suspension.

I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, let me associate myself completely with the remarks that the gentleman from Texas just made.

I do think that it is significant that we are able to negotiate on a bipartisan basis a 1-year extension to avoid these cuts to the doctors, and I do believe we need to work together on a bipartisan basis to achieve a permanent fix in the next Congress.

Ms. JACKSON LEE of Texas. Mr. Speaker, today I rise in support of the Senate amendment to H.R. 4994, the ''Medicare and Medicaid Extenders Act,'' which makes certain that our seniors and military families are able to continue seeing their doctors.

Scheduled for January 1 and through 2011, this bipartisan legislation stops the 25 percent cut in Medicare payments to doctors. This very important legislation protects and supports our doctors who are serving Medicare recipients and active duty military, their families, the Reserve members and military retirees whose access to healthcare is tied to Medicare through the TRICARE system. If we fail to pass this legislation we are doing an extreme injustice to numerous Americans who depend on these doctors and this Congress for their healthcare.

In my Congressional District, Riverside General Hospital (RGH), a member of the TRICARE network can ensure military families will be able to continue to see their doctors. Riverside General Hospital, formerly The Houston Negro Hospital was erected in 1926 in memory of Lieutenant John Halm Cullinan, 344th FA., 90th Div. AEP.

St. Joseph Medical Center, in Houston, Texas, in my district, the only hospital in the inner city of Houston, can now continue to provide access to Medicare beneficiaries to Houston's most needy patient population as a result of this legislation in its current form. Currently, St. Joseph's provides $14 million in uninsured care in the Houston Market.

St. Joseph Medical Center provides a full range of comprehensive medical and surgical services, such as, cardiology, cancer care, behavioral health, intensive care/critical care, emergency care, neurosurgery, orthopedics and pediatrics. St. Joseph Women's Medical Center, Houston's only full service women's hospital attached to a general acute care hospital, provides women's medical and surgical services, a family birthing center for moms and newborns, labor/delivery/recovery suites and a neonatal intensive care unit for premature or seriously ill newborns. The Level III Neonatal Intensive Care Unit is staffed by the Small Wonders Team of specially trained doctors, nurses and staff who provide the smallest patients with the best chance at life. Specialty services provided by St. Joseph include an advanced wound care center, behavioral medicine, blood conservation and management services, occupational medicine, sports medicine and rehabilitation, inpatient and outpatient diagnostic imaging, and Corporate Healthcare Connection, a partnership with Houston's corporate businesses that provides expedited care to their employees. A Houston institution for 120 years, St. Joseph Medical Center is also a major provider of psychiatric beds as it currently operates 102 of the 800 licensed beds in Houston.

For an entire year, this legislation provides thousands with a practical, invaluable, and stable solution for deserving patients and doctors. These doctors deserve payment for the aid they render and we would be doing an intensely unjust service to them by not ensuring their repayment. Furthermore, we would be building a shaky platform for our constituents by not ensuring healthcare and medicine to the elderly, unfortunate, or those who so altruistically serve or served our country.

Moreover, the bill is fully paid for according to the Congressional Budget Office. Furthermore, the CBO reports that it would serve to reduce the deficit by $2.8 billion over the next 10 years if the bill is passed. This is made possible by modifying the Affordable Care Act in the area of overpayments of tax credits to help individuals afford insurance. It is important to note that this bill's provision will in fact protect income based tax credits. Specifically, this provision would change the way individuals pay back overpayments when they receive a larger tax credit than they were eligible for based on their actual income for the year. Also, this legislation is highly supported by AARP and the American Medical Association.

Other extensions include:

The Transitional Medical Assistance (TMA), which allows low-income families to keep their Medicaid coverage as they move into employment and their income increases. Which is extremely important for those who are struggling to get on the their feet and make a way for themselves and their families. If we take away their assistance just as they are beginning to earn more money then we force those individuals to struggle to pay for more costly healthcare they cannot afford subsequently reducing their total income.

Extension of the Qualifying Individual (Q1) Program which allows Medicaid to pay the Medicare premiums for those with incomes 120–135 percent below the poverty line who are Medicare recipients.

Mr. Speaker, I urge my colleagues to support the passage of H.R. 4994, which greatly assists our countrymen and helps those who are elderly, poverty stricken, and those brave individuals who serve and served in our armed forces and their family members.

Further, however the major component to keeping our health care system working is to not reduce doctors' payments from medicare by 25% as of January 1, 2011. This bill will fix that inequity and extend current medicare payments to doctors. Until December, 2012.

This is good advice. I urge a ''yea'' vote.

Ms. SCHAKOWSKY. Mr. Speaker, I rise today in support of the Senate amendments to H.R. 4994.

I continue to believe that we need to make permanent reforms to Medicare's physician payment rules. Senior citizens and persons with disabilities need to know that they will be able to get high quality and timely care and that their doctors will be paid fairly and in a timely fashion. There is never really any question that Congress will act to prevent double-digit cuts in Medicare and TRICARE physician payments, but we should not have to debate these issues on a monthly basis.

The bill before us today does not provide a permanent solution as I would like, but it does provide a one-year fix, eliminating the confusion and concern that is created by very short-term measures to prevent cuts. I am pleased that it also includes an extension of the Medicare physician payment add-on for mental health, since we know that access to mental health services continues to be a problem in our communities.

While much of the focus has been on the physician payment issue, there are other provisions in the Medicare and Medicaid Extenders Act that will improve access to care

through December 31, 2011. Those include an extension of the exceptions process for Medicare therapy caps so that individuals who need additional services will not be forced to go without. It extends the Special Diabetes Programs, which are so important in dealing with the impacts of this terrible disease. The bill clarifies that orphan drugs are included in the 340B drug discount program for children's hospitals. It continues Medicare's Quality Individual program to help pay for Medicare Part B premiums for low-income seniors and people with disabilities and it extends Transitional Medical Assistance so low-income families don't lose critical Medicaid coverage as they move into employment.

Passage of the Medicare and Medicaid Extenders Act will make sure that the end of this year won't bring with it cutbacks in access to health care for millions of Americans. It gives us all of 2011 to make these year-long extensions permanent, and I will work hard to make sure that we use next year to do so.

Mr. WAXMAN. Mr. Speaker, I speak today in support of H.R. 4994, the ''Medicare and Medicaid Extenders Act of 2010.''

This legislation blocks a 25 percent fee cut that is scheduled for Medicare physician payments on January 1, 2011. A cut of that magnitude would jeopardize the access of seniors and people with disabilities to their doctors.

Likewise, military families who rely on TRICARE need this legislation, because TRICARE uses Medicare rates and would also face a huge fee cut on January 1.

The recent practice of Congress to legislate on physician payments several times per year needs to stop. Upon enactment, this will make the fifth SGR bill Congress has passed in 13 months.

I am pleased that this legislation, unlike other recent SGR bills, would address the problem for an entire year.

However, a 1-year solution is far less than the Medicare program ultimately needs. Congress must eventually confront the SGR permanently. The House has previously passed a permanent solution to the SGR problem. I hope that the next Congress is able to follow up on that work and fix this problem once and for all.

This bill also ensures the continued ability of Medicare beneficiaries to access therapy benefits to help them recover from illness. And it contains other important technical changes to maintain the smooth functioning of the Medicare and Medicaid programs.

Other provisions of this bill help low income Medicare and Medicaid beneficiaries. One provision helps low-income Medicare beneficiaries cover the cost of their Medicare Part B premiums. Another extends the transitional medical assistance program to help Medicaid beneficiaries as they work more hours and increase their earnings.

This legislation is completely paid for, and it is necessary. It passed the Senate by unanimous consent, and I hope that all Members of the House will support it as well.

One further note for purposes of interpretation. Section 204 of this bill contains a technical amendment to Section 340B of the Public Health Services Act. This language corrects an error in P.L. 111–152, the Health Care and Education Reconciliation Act of 2010, that inadvertently caused children's hospitals to lose access to orphan drugs at 340B prices. The language in Section 204 restores full access to orphan drugs at 340B prices for these hospitals. This amendment is retroactive as if included in P.L. 111–152. The intent of this retroactivity is to clarify congressional intent that there be no discontinuity in access to orphan drugs at 340B prices for childrens' hospitals. To the extent that drug manufacturers have not provided these discounts at any point between the enactment of P.L. 111–152 and the enactment of this legislation, they should do so retroactively, subject to HRSA or any other compliance and enforcement authority.

Mr. CONYERS. Mr. Speaker, I rise today in support of Senate amendments to H.R. 4994, the Medicare and Medicaid Extenders Act.

One of the most important priorities of Congress, regardless of our current economic downturn, is the financial well-being of our nation's hospitals, and the ability of patients to have access to medically necessary care when they need it.

Passage of the Senate amendments to H.R. 4994 accomplishes both goals by blocking a scheduled 25 percent cut in Medicare payments to doctors and extending current Medicare payment rates through December 31, 2011. Passage of the bill today by the House will send this legislation to the President's desk for his signature.

In order to have world class hospitals in the United States, we must have the needed funding to ensure that our nation's hospitals can provide the highest quality care possible. Passage of the Senate amendments to H.R. 4994 will help strengthen our hospitals, especially those located in our inner cities and rural areas. These hospitals are experiencing serious funding shortages, and are at risk of losing much needed doctors and medical staff.

This bill is fully paid for, and according to CBO, the bill would reduce the deficit by $2.8 billion over the next 10 years. This legislation also helps to protect access to doctors for Medicare beneficiaries and military families, given that payment rates for doctors in TRICARE, the health care program for active-duty servicemembers, National Guard and Reserve members, military retirees, and their families are tied to Medicare rates. Passage of the Senate amendments to H.R. 4994 is a good example of how Members of Congress working together in a spirit of bipartisan unity can improve the health and well being of all Americans.

I do want to raise some concerns with the way this bill is going to be paid for, which is to decrease the affordability credits for Americans that are needed to defray the costs of purchasing private insurance under the soon to be established health exchanges in 2014. I believe that this is tantamount ''to robbing Peter to pay Paul.'' This Congress should not get into the habit of viewing future benefits for low-income Americans as a source of funding for today's legislative initiatives. There are other more fair minded and progressive offsets which could have been utilized for this payment fix—such as taxing Wall Street or our nation's billionaires.

If we are going to make sure that Medicare doctors and hospitals are reimbursed at an appropriate rate over the next several years, we are going to have to be more serious and pragmatic about how to implement efficiencies in the Medicare program.

Medicare is a highly successful and efficient program, but it can't keep feeding the ''corporate medical monster'' forever. The time has come for the Federal Government to rein in the costs of for-profit hospital care by taking a more serious look at how we can reduce the costs of prescription drugs and medical technology—two of the most costly expenditures for hospitals and doctors.

Furthermore, we must pass H.R. 676, ''The U.S. National Health Care Act,'' so that all Americans can enjoy the benefits of a universal single payer system, which has successfully worked in every major industrialized country to contain the rising costs of health care and provide quality health care for all. If we created this system, then we would be able to pay our nation's physicians at optimal levels and provide America's hospitals and clinics with a more financially stable, predictable, and efficient health care payment system for years to come.

In the meantime, today's physician payment bill will allow today's Medicare beneficiaries to enjoy the care they have earned. I urge my colleagues to support the bill.

Mr. PALLONE. I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. STARK) that the House suspend the rules and concur in the Senate amendments to the bill, H.R. 4994.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

RECESS

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

Accordingly (at 10 o'clock and 41 minutes a.m.), the House stood in recess subject to the call of the Chair.

□ 1245

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. ALTMIRE) at 12 o'clock and 45 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:

Motion to concur in Senate amendments to H.R. 4994, by the yeas and nays;

H.R. 6412, de novo.

The first electronic vote will be conducted as a 15-minute vote. The second