

found that 75 percent of physicians whose patients had advanced directives were not even aware that those directives existed. This is a problem, Mr. Speaker, and I hope that as we get electronic medical records and HIT, Health Information Technology, becomes more sophisticated and interoperable, these advanced directives can be stored electronically and be made accessible to the medical staff in an instant, really, in a timely manner.

So, in conclusion, Mr. Speaker, I want to encourage all Americans to set aside time to have what may very well be one of the most vital conversations that any family can have.

I urge my fellow Members to vote in support of this resolution and to recognize the critical role of education in allowing Americans to effectively express their end-of-life wishes.

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

The SPEAKER pro tempore. Without objection, the gentleman from New York (Mr. TOWNS) will control the time.

There was no objection.

Mr. TOWNS. Mr. Speaker, I yield myself as much time as I may consume.

Mr. Speaker, I rise in strong support of H. Con. Res. 323, expressing congressional support for the goals and ideals of National Health Care Decisions Day.

As a cosponsor of this resolution, I understand the importance of making our health decisions clear to our family members and other loved ones through advanced directives. While it is very difficult for us to face the prospects of our own mortality, many of us write wills in order to ensure that our loved ones are adequately provided for in our absence. Unfortunately, we often do not take that care in making provisions regarding our end-of-life medical care.

Nobody can predict when disease, tragedy, or other medical conditions will render one unable to make medical decisions for ourselves. Accordingly, we must plan ahead in case of such a tragedy to ensure that our wishes are properly carried out.

Advanced directives are an integral part of any care-delivery plan. They are simply a statement by a competent person that articulates the medical, legal, and personal wishes regarding medical treatment in the event of future incapacity.

Where advanced directives are present, medical professionals, families, and loved ones are best able to make critical care decisions should a patient become unable to make sound judgments about their health care.

The resolution before us commemorates National Health Care Decisions Day on April 16, 2008. Although this specific day occurred last week, the goals and ideals of today should be recognized perpetually.

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This resolution encourages those 18 years of age and older to prepare ad-

vance directives. It also encourages medical, civic, educational, religious and other nonprofit organizations to promote advance directive preparation, particularly among their constituents.

I would like to thank my colleague on the other side of the aisle, Representative PHIL GINGREY, for his work in raising this important issue. Our colleagues in the Senate have already recognized the need to highlight advance directives, and I urge us here in the House to do the same.

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

Mr. GINGREY. Mr. Speaker, I just want to thank my friend from New York for his support of this resolution. And again, I want to thank the chairman of the committee, Mr. DINGELL, for allowing this to be brought to the floor under suspension and for his support, and for the support of the majority staff, and also to my distinguished colleague, the ranking member of Energy and Commerce, Representative BARTON, and the minority staff.

I urge all of my colleagues to support the resolution, as Representative TOWNS just said.

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

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan (Mr. DINGELL) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 323.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

PROTECTING THE MEDICAID SAFETY NET ACT OF 2008

Mr. DINGELL. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5613) to extend certain moratoria and impose additional moratoria on certain Medicaid regulations through April 1, 2009, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5613

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting the Medicaid Safety Net Act of 2008".

SEC. 2. MORATORIA ON CERTAIN MEDICAID REGULATIONS.

(a) EXTENSION OF CERTAIN MORATORIA IN PUBLIC LAW 110-28.—Section 7002(a)(1) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110-28) is amended—

(1) by striking "prior to the date that is 1 year after the date of enactment of this Act" and inserting "prior to April 1, 2009";

(2) in subparagraph (A), by inserting after "Federal Regulations" the following: "or in the final regulation, relating to such parts, published on May 29, 2007 (72 Federal Register 29748)"; and

(3) in subparagraph (C), by inserting before the period at the end the following: ", including the proposed regulation published on May 23, 2007 (72 Federal Register 28930)".

(b) EXTENSION OF CERTAIN MORATORIA IN PUBLIC LAW 110-173.—Section 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) is amended—

(1) by striking "June 30, 2008" and inserting "April 1, 2009";

(2) by inserting "including the proposed regulation published on August 13, 2007 (72 Federal Register 45201)," after "rehabilitation services"; and

(3) by inserting "including the final regulation published on December 28, 2007 (72 Federal Register 73635)," after "school-based transportation".

(c) ADDITIONAL MORATORIA.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to April 1, 2009, take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose any restrictions relating to a provision described in subparagraph (A), (B), or (C) of paragraph (2) if such restrictions are more restrictive in any aspect than those applied to the respective provision as of the date specified in paragraph (3) for such provision.

(2) PROVISIONS DESCRIBED.—

(A) PORTION OF INTERIM FINAL REGULATION RELATING TO MEDICAID TREATMENT OF OPTIONAL CASE MANAGEMENT SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), the provision described in this subparagraph is the interim final regulation relating to optional State plan case management services under the Medicaid program published on December 4, 2007 (72 Federal Register 68077) in its entirety.

(ii) EXCEPTION.—The provision described in this subparagraph does not include the portion of such regulation as relates directly to implementing section 1915(g)(2)(A)(ii) of the Social Security Act, as amended by section 6052 of the Deficit Reduction Act of 2005 (Public Law 109-171), through the definition of case management services and targeted case management services contained in proposed section 440.169 of title 42, Code of Federal Regulations, but only to the extent that such portion is not more restrictive than the policies set forth in the Dear State Medicaid Director letter on case management issued on January 19, 2001 (SMDL #01-013), and with respect to community transition case management, the Dear State Medicaid Director letter issued on July 25, 2000 (Olmstead Update 3).

(B) PROPOSED REGULATION RELATING TO REDEFINITION OF MEDICAID OUTPATIENT HOSPITAL SERVICES.—The provision described in this subparagraph is the proposed regulation relating to clarification of outpatient clinic and hospital facility services definition and upper payment limit under the Medicaid program published on September 28, 2007 (72 Federal Register 55158) in its entirety.

(C) PORTION OF PROPOSED REGULATION RELATING TO MEDICAID ALLOWABLE PROVIDER TAXES.—

(i) IN GENERAL.—Subject to clause (ii), the provision described in this subparagraph is the final regulation relating to health-care-related taxes under the Medicaid program published on February 22, 2008 (73 Federal Register 9685) in its entirety.

(ii) EXCEPTION.—The provision described in this subparagraph does not include the portions of such regulation as relate to the following:

(I) REDUCTION IN THRESHOLD.—The reduction from 6 percent to 5.5 percent in the threshold applied under section 433.68(f)(3)(i) of title 42, Code of Federal Regulations, for determining whether or not there is an indirect guarantee to hold a taxpayer harmless, as required to carry out section 1903(w)(4)(C)(ii) of the Social Security Act, as added by section 403 of the Medicare

Improvement and Extension Act of 2006 (division B of Public Law 109-432).

(II) CHANGE IN DEFINITION OF MANAGED CARE.—The change in the definition of managed care as proposed in the revision of section 433.56(a)(8) of title 42, Code of Federal Regulations, as required to carry out section 1903(w)(7)(A)(viii) of the Social Security Act, as amended by section 6051 of the Deficit Reduction Act of 2005 (Public Law 109-171).

(3) DATE SPECIFIED.—The date specified in this paragraph for the provision described in—

(A) subparagraph (A) of paragraph (2) is December 3, 2007;

(B) subparagraph (B) of such paragraph is September 27, 2007; or

(C) subparagraph (C) of such paragraph is February 21, 2008.

SEC. 3. FUNDS TO REDUCE MEDICAID FRAUD AND ABUSE.

(a) IN GENERAL.—For purposes of reducing fraud and abuse in the Medicaid program under title XIX of the Social Security Act, there is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, \$25,000,000, for each fiscal year (beginning with fiscal year 2009). Amounts appropriated under this section shall remain available for expenditure until expended and shall be in addition to any other amounts appropriated or made available to the Secretary for such purposes with respect to the Medicaid program.

(b) ANNUAL REPORT.—Not later than September 30 of 2009 and of each subsequent year, the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the activities (and the results of such activities) funded under subsection (a) to reduce waste, fraud, and abuse in the Medicaid program under title XIX of the Social Security Act during the previous 12 month period, including the amount of funds appropriated under such subsection (a) for each such activity and an estimate of the savings to the Medicaid program resulting from each such activity.

SEC. 4. STUDY AND REPORTS TO CONGRESS.

(a) SECRETARIAL REPORT IDENTIFYING PROBLEMS.—Not later than July 1, 2008, the Secretary of Health and Human Services shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that—

(1) outlines the specific problems the Medicaid regulations referred to in the amendments made by subsections (a) and (b) of section 2 and in the provisions described in subsection (c)(2) of such section were intended to address;

(2) detailing how these regulations were designed to address these specific problems; and

(3) cites the legal authority for such regulations.

(b) INDEPENDENT COMPREHENSIVE STUDY AND REPORT.—

(1) IN GENERAL.—Not later than July 1, 2008, the Secretary of Health and Human Services shall enter into a contract with an independent organization for the purpose of—

(A) producing a comprehensive report on the prevalence of the problems outlined in the report submitted under subsection (a);

(B) identifying strategies in existence to address these problems; and

(C) assessing the impact of each regulation referred to in such subsection on each State and the District of Columbia.

(2) ADDITIONAL MATTER.—The report under paragraph (1) shall also include—

(A) an identification of which claims for items and services (including administrative activities) under title XIX of the Social Security Act are not processed through systems described in section 1903(r) of such Act;

(B) an examination of the reasons why these claims for such items and services are not processed through such systems; and

(C) recommendations on actions by the Federal government and the States that can make claims for such items and services more accurate and complete consistent with such title.

(3) DEADLINE.—The report under paragraph (1) shall be submitted to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate not later than March 1, 2009.

(4) COOPERATION OF STATES.—If the Secretary of Health and Human Services determines that a State or the District of Columbia has not cooperated with the independent organization for purposes of the report under this subsection, the Secretary shall reduce the amount paid to the State or District under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) by \$25,000 for each day on which the Secretary determines such State or District has not so cooperated. Such reduction shall be made through a process that permits the State or District to challenge the Secretary's determination.

(c) FUNDING.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary without further appropriation, \$5,000,000 to carry out this section.

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Secretary of Health and Human Services with respect to the Medicaid program.

SEC. 5. ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS.

(a) ADDITION OF AUTHORITY.—Title XIX of the Social Security Act is amended by inserting after section 1939 the following new section:

“ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS

“SEC. 1940. (a) IMPLEMENTATION.—

“(1) IN GENERAL.—Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this title.

“(2) PLAN SUBMITTAL.—In order to meet the requirement of paragraph (1), each State shall—

“(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amendment under this title that describes how the State intends to implement the asset verification program; and

“(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

“(3) PHASE-IN.—

“(A) IN GENERAL.—

“(i) IMPLEMENTATION IN CURRENT ASSET VERIFICATION DEMO STATES.—The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before the date of the enactment of this section) to implement an asset verification program under this subsection by the end of fiscal year 2009.

“(ii) IMPLEMENTATION IN OTHER STATES.—The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of enrollees, in the aggregate for all such other States, by the end of the fiscal year involved:

“(I) 12.5 percent by the end of fiscal year 2009.

“(II) 25 percent by the end of fiscal year 2010.

“(III) 50 percent by the end of fiscal year 2011.

“(IV) 75 percent by the end of fiscal year 2012.

“(V) 100 percent by the end of fiscal year 2013.

“(B) CONSIDERATION.—In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

“(C) STATES SPECIFIED.—The States specified in this subparagraph are California, New York, and New Jersey.

“(D) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary approving, the implementation of an asset verification program in advance of the deadline otherwise established under such subparagraph.

“(4) EXEMPTION OF TERRITORIES.—This section shall only apply to the 50 States and the District of Columbia.

“(b) ASSET VERIFICATION PROGRAM.—

“(1) IN GENERAL.—For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

“(A) requires each applicant for, or recipient of, medical assistance under the State plan under this title on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are material to the determination of the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1101(a) of the Right to Financial Privacy Act but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(I) of such Act) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

“(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

“(2) PROGRAM DESCRIBED.—A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii).

“(c) DURATION OF AUTHORIZATION.—Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

“(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this title;

“(2) the cessation of the recipient's eligibility for such medical assistance; or

“(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

“(d) TREATMENT OF RIGHT TO FINANCIAL PRIVACY ACT REQUIREMENTS.—

“(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act for purposes of section 1103(a) of such Act, and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act.

“(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

“(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is

deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act and of section 1102 of such Act, relating to a reasonable description of financial records.

“(e) **REQUIRED DISCLOSURE.**—The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

“(f) **REFUSAL OR REVOCATION OF AUTHORIZATION.**—If an applicant for, or recipient of, medical assistance under the State plan under this title (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

“(g) **USE OF CONTRACTOR.**—For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with section 1903(i)(2). In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

“(h) **TECHNICAL ASSISTANCE.**—The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

“(i) **REPORTS.**—A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

“(j) **TREATMENT OF PROGRAM EXPENSES.**—Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of section 1903(a), in the same manner as State expenditures specified in paragraph (7) of such section.”

(b) **STATE PLAN REQUIREMENTS.**—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (69) by striking “and” at the end;

(2) in paragraph (70) by striking the period at the end and inserting “; and”;

(3) by inserting after paragraph (70), as so amended, the following new paragraph:

“(71) provide that the State will implement an asset verification program as required under section 1940.”

(c) **WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR NONCOMPLIANT STATES.**—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (22) by striking “or” at the end;

(2) in paragraph (23) by striking the period at the end and inserting “; or”;

(3) by adding after paragraph (23) the following new paragraph:

“(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

“(A) the State demonstrates to the Secretary’s satisfaction that the State made a good faith effort to comply;

“(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

“(C) not later than 12 months after the date of such submission (and approval), the State

fulfills the terms of such corrective action plan.”

(d) **REPEAL.**—Section 4 of Public Law 110–90 is repealed.

SEC. 6. ADJUSTMENT TO PAQI FUND.

Section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(1) in subparagraph (A)(i)—
(A) in subclause (III), by striking “\$4,960,000,000” and inserting “\$3,790,000,000”; and

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

“(IV) For expenditures during 2014, an amount equal to \$3,690,000,000.”;

(2) in subparagraph (A)(ii), by adding at the end the following new subclause:

“(IV) 2014.—The amount available for expenditures during 2014 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.”; and

(3) in subparagraph (B)—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by striking the period at the end and inserting “; and”;

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

“(iv) 2014 for payment with respect to physicians’ services furnished during 2014.”

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Michigan (Mr. DINGELL) and the gentleman from Texas (Mr. BARTON) each will control 20 minutes.

The Chair recognizes the gentleman from Michigan.

GENERAL LEAVE

Mr. DINGELL. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on the bill under consideration.

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

There was no objection.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I rise today in support of H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008. This is a bipartisan bill, critically important to our Nation’s safety net. The Committee on Energy and Commerce reported it favorably with a strong bipartisan vote of 46–0.

I want to commend and thank our subcommittee chairman, Mr. PALLONE, and our distinguished colleague and co-sponsor of the legislation, Mr. MURPHY of Pennsylvania, for their leadership on this matter. And I want to express to my good friends and the ranking members on the committee and the subcommittee, Mr. BARTON and Mr. DEAL, for their superb cooperation.

I also want to thank my colleagues on the Committees on Ways and Means and Financial Services for the splendid cooperation and help they gave us in moving this legislation to the floor expeditiously. The support of Chairmen Rangel and Stark were both necessary and very much appreciated.

H.R. 5613 places a 1-year moratorium on seven regulations recently issued by

the U.S. Department of Health and Human Services. The regulations would have restricted payments to critical safety net providers such as hospitals and nursing homes, as well as payments for graduate medical education training. The regulation would have reduced or eliminated payments that allow children with severe mental illness to remain in family settings, and payments to schools transporting poor children with disabilities. The Governors of all 50 States oppose these rules, as do the State Medicaid directors, State legislators, and the National Association of Counties.

More than 2,000 national and local groups such as the American Hospital Association, the American Federation of Teachers and the March of Dimes support this legislation. They know of the devastating effect these rules would have upon local communities, upon the hospitals, and upon vulnerable beneficiaries.

Without this moratorium, schools would be forced to lay off workers starting in June. Hospitals and nursing homes would be forced to cut off services and to lay off workers as well. In troublesome economic times, we cannot afford to lose good-paying jobs or to cut services that enable people with disabilities to be gainfully employed.

H.R. 5613 will postpone the implementation of these seven rules for 1 year, giving Congress time to evaluate the effect they would have on States, providers and beneficiaries.

I want to again commend my colleagues on both sides of the aisle, including my dear friend, Mr. BARTON, and Mr. DEAL for their leadership and hard work on this matter. I urge my colleagues to vote for H.R. 5613.

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

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

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, I rise today to join my good friend, Chairman JOHN DINGELL of the Energy and Commerce Committee, in support of H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008.

Given the fact that Secretary Leavitt of Health and Human Services indicated that he would recommend to the President of the United States that he veto the bill before us in its current form, I do wish we could have brought the bill to the floor under a rule with several potential amendments and a motion to recommit so that we can have a little bit fuller debate rather than putting it on the suspension calendar. Having said that, I am very glad that it is coming to the floor as a stand-alone bill, and that Chairman DINGELL and Chairman PALLONE of the subcommittee have followed regular order in passing this legislation.

I want to thank Chairman DINGELL and Chairman PALLONE for holding a

legislative hearing as well as a subcommittee markup and a full committee markup on the bill that's now before us. I also want to thank them for having an open process, where staff on both sides of the aisle could work together, amendments could be shared, and some of those amendments could be agreed upon and incorporated into the bill that's before us today. I would not have been able to support H.R. 5613 as originally introduced, but I can support the bill that's before us this afternoon. I'm proud that, on occasion, we do put good public policy ahead of partisan politics, and the bill before us, again, is an example of what I believe to be better public policy.

I do hope that we take this opportunity to take the issue before us, if this bill becomes law, and actually work on it for the year that the moratorium is in place. The bill before us would place a year-long moratorium on seven Medicaid rules. It does not mean that the suspended rules themselves are all bad and don't address a problem that needs to be addressed. It does mean that many of the interest groups and many of the States had significant problems with those rules, and so it was felt prudent to have a moratorium where we could hopefully, in the interim, determine how to fine tune and maybe change some of those rules.

We do need to save money in Medicaid. We do need to do something on this system of intergovernmental transfers. For those of you who don't understand what an intergovernmental transfer is, as used in Medicaid, a State will give money to the Federal Government that is then matched by the Federal Government and sent back to the State. The State will give some of that money to, in this case a hospital system, but then keep some of the money that it initially gave. So it's kind of a shell game where you put up some money to get it matched, and once you put up you use for another purpose, not for a health purpose, but maybe for a different purpose, like building a highway or something like that. One of the suspended rules would have addressed this intergovernmental transfer, and I hope that in the next year, on a bipartisan basis, we can address the intergovernmental transfer issue itself.

Mr. DINGELL. Will the gentleman from Texas yield?

Mr. BARTON of Texas. I would be happy to yield.

Mr. DINGELL. I want to again commend my friend from Texas for his superb performance on this legislation. And I want to assure him that I share his concerns on the intergovernmental transfer matter, and that we will be going into it. I thank my friend.

Mr. BARTON of Texas. I thank the distinguished chairman.

We simply cannot pretend on a day that we're suspending these rules that there are not fundamental financial difficulties facing Medicaid. So while we agree to suspend the rules for the next year, I hope we can also agree, as the chairman just indicated that he

did, that we're going to continue to work on the problems these rules were designed to address so that over time we can reach agreement on how to save money under Medicaid.

I do believe the bill before us is a good bill. It does have a pay-for. It is, on a net basis, a slight revenue increase to the Federal Treasury, so it is paid for. And if we spend the next year working together, if we implement some of the things in this bill, the bill gives \$25 million a year to combat waste, fraud and abuse in Medicaid, if we use that money wisely, we will uncover some savings. And if we look at some of these suspended rules, we can perhaps work together to fine tune them so that a year from now, at the beginning of the next administration, we don't have to extend the moratorium.

In short, Mr. Speaker, while this is not a perfect bill, it's a good bill. Don't let the pursuit of perfection prevent the accomplishment of what is something that is good and possible.

I would urge a "yes" vote on H.R. 5613, especially on my side of the aisle, among the Republicans in the House of Representatives.

With that, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, I rise in strong support of the Dingell-Murphy bill, H.R. 5613, which would delay seven Medicaid regulations that would shift billions of dollars in costs from the Federal Government to States, counties, school districts, hospitals, and other medical providers. There is absolutely no justification for such a cost shift, especially at a time when many States are struggling to avoid budget cuts as their economies slow and revenues decline. The bill would delay the implementation of these regulations until April 1, 2009.

The Oversight Committee held hearings on this matter. We heard testimony from public and teaching hospital administrators, an emergency room physician, a child welfare worker and a school nurse. They explained how the regulations would shift costs to States and localities and what that cost would mean for access to services for beneficiaries. We also heard from a representative from the Centers for Medicare and Medicaid Services, which issued these regulations.

And since Medicaid is a Federal-State program, one would think that when the Federal Government changes the rules, as these regulations would do, it would first try to determine what the impact of these changes would be on the different States. Well, we followed up with the head of the CMS for Medicaid, and he told us that he had not done a State-by-State specific analysis of the impact and he had no plans to do such an analysis. So our committee made our own analysis. We did a survey of Medicaid directors for 43 States and the District of Columbia, and they told us that if CMS were al-

lowed to implement all seven Medicaid regulations, their States would lose nearly \$50 billion in Federal funds over the next 5 years. The result of these cost shifts would not be greater efficiency, it would not be a savings of money, it would simply come out of the reimbursements, and fewer eligible populations. They would disrupt the existing systems for care of fragile populations, such as adults with severe mental illness or children with special health care needs. They would undercut the financial stability of hospitals and emergency rooms that treat Americans without health insurance. They would impose large, new administrative burdens and costs on State Medicaid programs without any offsetting policy benefit.

In short, the best professional judgment was that the regulations would have harmful fiscal and programmatic consequences for their States and the people that look to the Medicaid program as the safety net for health care.

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The bill before us gives the department and the Congress the time to look into these issues in the detail they deserve without making fundamental changes in Federal Medicaid policy.

I urge support for this bipartisan legislation.

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

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from California (Ms. HARMAN).

Ms. HARMAN. Mr. Speaker, it's an honor to serve under Chairman DINGELL on the Energy and Commerce Committee and to support this effort to keep the Medicaid safety net intact. That our chairman shepherded this must-pass bill through our committee with unanimous support is testament to his enormous legislative skill and bipartisanship.

Unless we pass this bill, Mr. Speaker, public hospitals and the essential services they provide will be at grave risk. A major public hospital in my district, Harbor-UCLA Medical Center, is among them. It is the only level 1 trauma center near top terror targets like LAX and the ports of Long Beach and L.A. In the event of an attack, Harbor would be on the front lines. As a teaching hospital, it helps train the next generation of doctors.

Mr. Speaker, if all seven Medicaid regulations are implemented, Los Angeles County will lose \$240 million in annual funding, the equivalent of closing a public hospital like Harbor. Harbor is already overcrowded. It needs more help, not less. It needs to offer more services, not to close. H.R. 5613 will stop these catastrophic cuts, and it deserves our full support.

I urge our colleagues to vote "aye" and to join in overriding a White House veto should one occur.

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

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

The distinguished gentleman from Pennsylvania (Mr. TIM MURPHY) worked very hard on this important

legislation and is a cosponsor of it. Regrettably, he is detained, unfortunately, on an aircraft and is not able to be with us today to speak in favor of this bill on which he worked so hard. And I want the RECORD to show that the House owes the distinguished gentleman from Pennsylvania (Mr. TIM MURPHY) a real debt of thanks for his hard work here and for his remarkable leadership.

Mr. Speaker, I now yield 2 minutes to my dear friend the gentleman from New York (Mr. TOWNS).

Mr. TOWNS. Mr. Speaker, I rise to commend Chairman DINGELL and, of course, Congressman MURPHY and Congressman BARTON for placing this 1-year moratorium on the CMS Medicaid rules that would devastate patients, persons with disabilities, hospitals, States, and our entire safety net. Instead, these are the very entities and people that we should be helping, not hurting. CMS went well beyond the authority Congress allowed in enacting these rules.

Therefore, as a cosponsor, I urge my colleagues to vote in favor of this measure and support our Nation's Governors who have called for this moratorium and rightfully so. So I urge my colleagues to support this legislation.

Mr. BARTON of Texas. Mr. Speaker, I simply want to reiterate that as the ranking member on the Energy and Commerce Committee, I strongly support this piece of legislation. It did receive the votes of every Republican on the committee. It passed 46-0. I had wished it would not have been a suspension calendar bill, but I am happy it is a stand-alone bill, and I would encourage my colleagues to vote for this bill.

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

Mr. DINGELL. Mr. Speaker, I want to thank again my colleague from Texas. He is always a gentleman.

I want to note that last night the Commerce Committee dedicated a picture hung in the committee in honor of our good friend Mr. BARTON. It is a fine-looking picture of a distinguished former chairman of the committee, and I would urge my colleagues, if they want to look at a distinguished Member of this body hanging on the wall in the committee and to look at a very fine piece of art, they should come over and see the excellent picture of our good friend Mr. BARTON hanging there in the committee.

Mr. BACA. Mr. Speaker, I rise in support of H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008. After unsuccessful attempts at S-CHIP over the last several months, over 33,000 children in my district are still uninsured.

Now the most vulnerable of beneficiaries of Medicaid, children and the disabled, are faced with a major crisis. This bill has bipartisan support, this is not about politics. It's about helping hardworking families and the poorest among us.

This bill includes a moratorium of 7 CMS regulations, preventing the stripping of over

\$20 billion in Federal Medicaid funding over the next 5 years to States for vital programs and services. These programs and services will only shrink and shrivel if they are put against the wall to eat up these costs.

Even school districts, like Rialto Unified School District from my district, will face difficult challenges in providing direct health services to the 30,000 students it currently serves.

Cutting these valuable services at a time when many States, including California are facing record budget deficits is not an option. The poorest amongst us on Medicaid are most affected. We cannot turn our backs during these troubling times of increasing foreclosures and rising gas prices.

Cancer does not distinguish between incomes, why should health care coverage?

I support H.R. 5613, and urge my colleagues to do the honorable thing and vote for this bill.

Mr. STARK. Mr. Speaker, I rise to express my strong support for H.R. 5613, the "Protecting the Medicaid Safety Net Act of 2008." This bill stops George Bush's draconian attempt to gut the Medicaid program, which provides medical care to millions of low-income children and families.

If we fail to enact this bill, more than \$20 billion in vital Federal funding for States will disappear. This is \$20 billion that helps schools provide transportation for physically disabled children, allows local governments to contribute to the State Medicaid share, and trains physicians.

This President has presided over the greatest transition from boom to bust since the 1920s. As families face foreclosure and rising food and gas costs, States see declining sales tax receipts and greater numbers in need of assistance. Our President would add insult to injury for working families by dismantling their safety net.

The seven regulations proposed by the Bush administration would undermine longstanding practices upon which States have built their Medicaid programs. The regulations are opposed by a bipartisan coalition of lawmakers; all the Nation's Governors from both sides of the aisle; and a host of public health, physician, and patient advocates. The bill passed unanimously out of the Energy and Commerce Committee. In this day and age, that is a remarkable phenomenon. I am proud to join colleagues from both sides of the aisle to vote in favor of this moratorium and to protect the health care safety net for America's working families.

Ms. MOORE of Wisconsin. Mr. Speaker, today I join a bipartisan House to stand up to the Bush administration to prevent it from irresponsibly slashing the Medicaid budget. States that work with the Federal government to run and fund Medicaid programs are already facing budgetary restraints, flat funding, and shortfalls. The administration's proposed cuts to Medicaid would exacerbate their budgetary crunch, and would directly affect the quality of care given to low-income kids, seniors, families and people living with disabilities.

The bill before us today, H.R. 5613, would place a 1-year moratorium on seven Medicaid regulations proposed by the administration. This 1-year moratorium would give Congress more time to evaluate the potential effects of his proposed cuts on State Medicaid programs and the individuals that they serve. Several

groups have warned that the unexpected slashes in Federal Medicaid dollars could force States to shift their Medicaid costs to patients, who would be hard pressed to make up the differences in health care costs. At present, some 30 million low-income children depend on the Medicaid program.

The Government Accountability Office testified that it had not recommended the specific changes proposed by the administration, nor had officials there had time to adequately study the potential effects of these changes for 6 of the 7 regulations. Before the President starts tinkering with domestic programs upon which millions of our most vulnerable citizens rely, he owes it to them to do his homework. If he won't, then Congress owes it to the American people to investigate his proposed changes so we can fully understand their effect on poor and working families.

Nearly 2,000 groups from across the country, including school districts, hospitals, case management providers, and organizations serving people with disabilities and mental illnesses have joined us in support of the Protecting the Medicaid Safety Net Act. I am proud to be a cosponsor of this bill and urge my colleagues to cast their votes in favor of it.

Mr. UPTON. Mr. Speaker, I rise today in support of H.R. 5613 the Protecting the Medicaid Safety Net Act, and urge my colleagues to join me in voting for it.

Last week, my colleagues and I on the Energy and Commerce Committee unanimously approved H.R. 5613, the Protecting the Medicaid Safety Net Act. This bill places moratoria on seven regulations issued by the Center for Medicare and Medicaid Services, CMS. If allowed to go into effect as currently written, these regulations would seriously erode federal funding to the states for a range of Medicaid services, including rehabilitation and medical services for schoolchildren with disabilities, and would totally eliminate federal Medicaid matching funds for Graduate Medical Education at a time when my state is already in the grip of a growing physician shortage.

I am particularly concerned about the detrimental effect that these regulations would have on students and schools in my district and districts across the country. Under the Individuals with Disabilities Education Act, schools are required to provide medical and rehabilitation services that are necessary for children to enter and continue to attend school. If federal matching funds are reduced or eliminated, our schools will still be required pay for these services, meaning other vital services and programs would have to be significantly cut back or eliminated.

Another major concern of mine is the extent to which these regulations would reduce or eliminate federal matching payments for many of our community hospitals, seriously undermining access to care for poor and disabled women, children, and persons with disabilities. Our hospitals are already struggling under low Medicaid reimbursement rates and higher rates of uncompensated care as my State's economy has worsened. Like schools, hospitals are under a federal mandate—this one to examine and stabilize every patient who walks through their emergency room doors. These regulations could significantly increase hospitals' burden of uncompensated care.

I am also concerned about provisions in several of the regulations that could well undo the progress we have made over many years in enabling persons with mental and physical

disabilities to live independently and participate as fully as they are able in the workforce and the life of their communities rather than being confined to institutional settings.

Because of all these factors, I again encourage my colleagues to join me in voting for this bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise in strong support of H.R. 5613, the Protecting Medicaid Safety Net Act. The rules issued by CMS in August were said to be cost saving measures and a way to reduce waste, fraud, and abuse.

If these 7 regulations go into effect Texas would lose \$3.4 billion in Federal Medicaid funding over the next 5 years and nationwide cuts to Medicaid funding could total around \$50 billion. These regulations attack the core mission of Medicaid by eliminating much needed services for children, the elderly, and the poor.

These cuts will also have a devastating impact on state's Medicaid funds; consequently hurting the most vulnerable populations who are helped by the Medicaid safety net. This population accesses services and support care from Medicaid because they cannot access services elsewhere due to costs or restrictions on benefits.

If these regulations go into effect, I don't know where the states will find the funds to continue operating programs such as school administrative and transportation services, coverage for rehabilitative services, and outpatient hospital services. Especially since the lack of Medicaid funding will create budget crises in most states as they scramble to pay for services or eliminate them altogether.

This bill gives Congress enough time to understand the consequences of these regulations and come up with a solution we all can agree on rather than cutting these necessary services.

I am disappointed that the Administration has threatened to veto this bill. This piece of legislation is the result of a lot of hard work on both sides of the aisle.

I am particularly upset that the Administration seems to have forgotten once again about its Texas roots. Texas, along with California and New York stand to lose the largest amount of funding from these Medicaid cuts and this is money our states cannot afford to lose.

This bill has the support of 2,000 organizations and the National Governors Association. I urge my colleagues to support this bill and stop these cuts.

Mr. GRIJALVA. Mr. Speaker, over the past year, the Centers for Medicare and Medicaid Services, CMS, have introduced a series of Medicaid regulations that have caused grave concern to our States and beneficiaries. States are struggling as the economy sinks into recession, and these proposed regulations, if not suspended, will add billions in Medicaid costs to our States at a time when their tax revenues are falling and Medicaid caseloads are growing.

The seven regulations issued by CMS erode the foundation of the Medicaid system by preventing beneficiaries from accessing the care they need. These proposed regulations would endanger access to care by severely limiting payments to public hospitals, eliminate coverage for outpatient services that keep beneficiaries from unnecessary emergency room use, and by restricting support for transportation services for children with disabilities.

I would like to take this opportunity to thank Chairman DINGELL for his superb leadership on this issue and for introducing and garnering bipartisan support for this unfortunate but very necessary moratorium. This important legislation will help protect beneficiaries from harmful cuts and alleviate the immediate concerns that the Medicaid regulations cause for long term care patients, residents and providers alike. The bill also establishes an independent review of these regulations prior to the expiration of the moratorium next year. In addition, it provides \$25 million to HHS each year, beginning in FY 2009, to fight fraud and abuse in the Medicaid program.

This moratorium is a temporary fix, allowing Congress an opportunity to review these regulations as thoroughly as possible before they are implemented and the burden is borne by our constituents.

While CMS argues that these changes will create efficiencies in the program, there is no evidence to support this claim. What is known is that these changes will cause extreme harm to our most vulnerable citizens—low-income children, the disabled, and the elderly. By utterly disregarding the immense public outcry surrounding the enactment of these rules, this administration is placing desperately needed services in jeopardy without thoroughly weighing the effects these regulations will have on States.

Now more than ever, in the face of major State budget deficits, we cannot allow the Federal Government to make major regulatory changes to Medicaid that will result in billions of additional costs to states.

I am a proud, original cosponsor of Chairman DINGELL's H.R. 5613, the Protecting the Medicaid Safety Net Act of 2008 and urge all my colleagues in this 110th Congress to stand with me and stop this Administration from implementing these foolish and potentially devastating regulations.

Mr. VAN HOLLEN. Madam Speaker, I rise in strong support of the Protecting the Medicaid Safety Net Act of 2008.

Since its inception, Medicaid has been a joint State and Federal partnership to provide health care to the country's neediest and most vulnerable populations. Unfortunately, the Centers for Medicare and Medicaid Services, CMS, recently issued a series of Medicaid regulations that will significantly shift costs to States and restrict services to needy individuals. These regulations will force States to stop providing beneficiaries access to certain Medicaid services.

Among the damaging Medicaid regulations issued by CMS, I am especially concerned about the restrictive rules on targeted case management services that help people with disabilities remain in their community. Nearly 200,000 people in Maryland receive some type of Medicaid case management services, and these new rules will put more than \$60 million in Federal funds for Maryland at risk. CMS also proposes to eliminate or severely restrict Federal Medicaid funding for rehabilitation services, graduate medical education, hospital outpatient services, safety net institutions, and school-based transportation and outreach programs. While CMS claims that the elimination of \$20 billion in Federal Medicaid funding will create efficiencies in the program, it did not consult with Congress on these far reaching regulations.

With so many States, including Maryland, facing huge budget shortfalls and trying to fig-

ure out how to provide Medicaid services to their populations, now is not the time for the Federal Government to cut back on its share of funding. The legislation before us today would delay implementation of the regulations put forth by CMS so that Congress can examine their full impact.

Mr. Speaker, we have a responsibility and an obligation to our vulnerable citizens—low-income children, the disabled, and the elderly—to effectively provide access to adequate and quality health care services. I urge my colleagues to support this bipartisan bill.

Mrs. CHRISTENSEN. Mr. Speaker, I rise today in full support of H.R. 5613—the Medicaid Safety Net Act of 2008.

The millions of people who depend on this critical safety net and I thank and applaud Chairman DINGELL for once again protecting our Nation's critically important Medicaid program.

It is a shame that every year Democrats have to fight back at least one attempt to cut funding and provisions in this program that is so vital to the Nation's poor—the majority of which are people of color.

The administration and the Secretary's policies are going in the absolute wrong direction. Rather Medicaid and Children's Health Insurance funding needs to be increased to meet the needs of the increasing numbers of un- and under-insured which includes 9 million children. This administration's failed economic policies have left more people vulnerable.

Racial and ethnic minorities suffer worse morbidity and mortality because of lack of access. Caps on Medicaid in the territories don't even allow us to cover residents at 100 percent of poverty and per capita spending is a shamefully small fraction of that of our fellow Americans in the States.

This Nation's healthcare system as we all know has become a sick-care system and not only is it not doing a good job at that, it is in crisis and on the verge of catastrophe.

The proposed actions restricting payments for graduate medical education and blanket regulations against payment for certain services, threaten to not only make the healthcare situation in this country worse for the poor, but for everyone, and to threaten the competitiveness and security of our Nation.

I look forward to the new Democratic administration, who will work with Chairman DINGELL and others to transform health care in this country and reduce the skyrocketing costs through emphasis on prevention and equal access to quality, comprehensive culturally competent care for everyone who lives here. The foundation of this effort must be stronger Medicaid and SCHIP.

By stopping the assault on these two programs; by stopping payments to hard working providers and for the training of the healthcare workforce needed, we set the stage for that transformation to begin.

Thank you Mr. Chairman, for your continued leadership.

I urge passage of H.R. 5613 to protect this important safety net.

Mr. PAYNE. Mr. Speaker, I rise to express my strong support for the passage of H.R. 5613, the Protecting the Medicaid Safety Net Act. I commend my colleagues Representative DINGELL and Representative MURPHY for introducing this bill, which would extend until March 31, 2009 the moratorium on several Medicaid regulations that would strip an estimated \$20 billion over 5 years from the Medicaid program.

Mr. Speaker, for more than 40 years, Medicaid has served as the Nation's health care safety net, providing access to health services for millions who cannot afford private insurance in a dynamic and changing economy.

Today, more than 57 million children, poor, disabled and elderly individuals rely on Medicaid for care. The program now serves more people than Medicare, and with the ranks of the uninsured growing, and the threat of an economic recession, the Medicaid program is more important than ever.

Mr. Speaker, hospitals are the backbone of America's health care safety net, providing care to all patients who come through their doors, regardless of their ability to pay. But, hospitals are experiencing severe payment shortfalls when treating Medicaid patients.

Despite these financial pressures, the Administration continues to call for further cuts in federal funds for the Medicaid program that will affect hospitals and the patients they serve.

Despite concerns raised by Congress, CMS continues to take steps to implement these regulations. These rules range from limiting payments for teaching hospitals, public hospitals and hospital outpatient services to reducing school-based services for children and case management for the disabled.

Last year, Congress imposed a year-long moratorium (P.L. 110–28) on two regulations the proposed and final cost-limit rule and the proposed graduate medical education (GME) rule. The moratorium on implementation of these rules expires May 25, 2008.

CMS's regulatory budget-cutting policies will have a devastating effect on my home State of New Jersey's Medicaid program, along with the hospitals and physicians serving our Nation's most vulnerable population—poor children and mothers, the disabled and elderly individuals. Much of Congress has expressed opposition to these rules.

This bill would delay implementation of regulations affecting: CPEs; IGTs; GME; coverage of rehab services for people with disabilities; outreach and enrollment in schools, in addition to specialized medical transportation to school for children covered by Medicaid; coverage of hospital outpatient services; case management services that allow people with disabilities to remain in the community; and state provider tax laws.

Mr. Speaker, there is no question that CMS's regulatory budget-cutting policies will have a devastating effect on my home State of New Jersey's Medicaid program, along with the hospitals and physicians serving our Nation's most vulnerable population—poor children and mothers, the disabled and elderly individuals.

Mr. Speaker, we need to pass H.R. 5613 today. I urge my colleagues to vote for this bill legislation.

Mr. DINGELL. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan (Mr. DINGELL) that the House suspend the rules and pass the bill, H.R. 5613, as amended.

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. BROUN of Georgia. 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.

WORLD GLAUCOMA DAY

Mr. TOWNS. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 981) recognizing March 6, 2008, as the first-ever World Glaucoma Day, established to increase awareness of glaucoma, which is the second leading cause of preventable blindness in the United States and worldwide, as amended.

The Clerk read the resolution.
The text of the resolution is as follows:

H. RES. 981

Whereas glaucoma is a progressive disease of the optic nerve, robbing individuals of both peripheral and central vision;

Whereas glaucoma affects all age groups, including infants, children, and the elderly;

Whereas glaucoma disproportionately affects underserved minority populations, with African-Americans having a three times greater risk of developing this disease than White Americans, and it is the leading cause of irreversible vision loss in African-Americans and Hispanics;

Whereas glaucoma is the second leading cause of preventable vision loss in the United States, afflicting 2,200,000 Americans, and it is the leading cause of permanent blindness worldwide, afflicting 67,000,000 persons;

Whereas awareness is absolutely crucial, as glaucoma often has no symptoms until vision loss occurs, and it is estimated that, in the United States, more than half of the individuals with glaucoma are unaware that they have it and, in developing countries, 90 percent of individuals with glaucoma are unaware that they have it;

Whereas with early diagnosis and ongoing treatment, 90 percent of the cases where blindness occurs can be avoided and awareness is crucial, so that individuals with known risk factors for glaucoma and those over the age of 40 should have regular, comprehensive eye examinations that include careful evaluation of the optic nerve and measurement of eye pressure;

Whereas the National Eye Institute ("NEI") within the National Institutes of Health ("NIH") has been a worldwide leader in glaucoma research, elucidating the genetic basis of different types of the disease (including risk factors) and the potential for gene therapy approaches, identifying factors that can protect the optic nerve from damage, evaluating the potential for optic nerve cell regeneration, and better understanding how elevated intraocular pressure leads to optic nerve damage and how pressure-reducing drugs ultimately developed from NEI-led research can reduce glaucoma progression;

Whereas it is the role of the NEI to support research to prevent, diagnose, and cure glaucoma-related vision impairment and blindness, which disproportionately affects underserved minority populations; and

Whereas the public needs to know the insidious nature of glaucoma, that there are means for detecting and treating it to save sight, and the importance of compliance associated with those treatments, and the first-ever World Glaucoma Day is an observance planned to increase global awareness in that regard: Now, therefore, be it

Resolved, That the United States House of Representatives—

(1) recognizes the first-ever World Glaucoma Day;

(2) supports the efforts of the National Eye Institute within the National Institutes of Health to continue research on the causes of glaucoma, including genetic and environmental risk factors, glaucoma prevention, the relationships between damage to the optic nerve and loss of vision, societal and individual impacts, diagnostics, and treatment to save and potentially restore sight; and

(3) congratulates the American Glaucoma Society for its efforts to expand awareness of the prevalence and economic burden of glaucoma.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. TOWNS) and the gentleman from Texas (Mr. BARTON) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. TOWNS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the resolution under consideration.

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

There was no objection.

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

I rise today in support of H. Res. 981, recognizing March 6, 2008, as the first-ever World Glaucoma Day. As a co-sponsor of this resolution, I am proud to speak out in favor of greater support for glaucoma awareness and prevention.

Glaucoma is the second leading cause of preventable vision loss in the United States and the leading cause of permanent blindness worldwide. It afflicts 67 million people by some estimates. While glaucoma affects all age groups, it is of special concern to me because it disproportionately affects underserved minority populations, particularly African Americans over age 40 and Mexican Americans over 60.

The resolution before us supports the observance of World Glaucoma Day, which would raise awareness about glaucoma on a global scale. Awareness is especially important since nearly 90 percent of individuals with glaucoma are unaware that they have it. Moreover, regular comprehensive eye exams can lead to early diagnosis and treatment that can lessen the impact of this devastating disease.

The resolution also supports the efforts of the National Eye Institute and its commitment to continue research on the causes of glaucoma. By learning more about the causes of this insidious disease, we may one day find a cure.

The resolution also congratulates the American Glaucoma Society for its efforts to raise awareness about the prevalence of the disease. The American Glaucoma Society helps to preserve vision by supporting glaucoma specialists and scientists through the advancement of education and research.