Dissenting Views
of
Reps. John D. Dingell, Henry A. Waxman, Edward J. Markey, Rick Boucher, Edolphus Towns, Frank Pallone, Jr., Sherrod Brown, Bart Gordon, Bobby L. Rush, Anna G. Eshoo; Bart Stupak, Eliot L. Engel, Albert R. Wynn, Gene Green, Ted Strickland, Diana DeGette, Lois Capps, Michael F. Doyle, Tom Allen, Jim Davis, Janice D. Schakowsky, Hilda L. Solis, Charles A. Gonzalez, Jay Inslee, Tammy Baldwin, and Mike Ross
on
Title II - Medicaid, Katrina Health Care Relief, and Katrina and Rita Energy Relief Budget Reconciliation Recommendations

SUBTITLE A - MEDICAID

The House Republican Budget Resolution calls for $35 billion or more in mandatory spending cuts, at least $10 billion of which are to come out of Medicaid. At the same time, the Resolution calls for $106 billion in new tax cuts. And the Republican Budget Resolution actually increases the deficit by $35 billion as a result of continued tax cuts benefitting the richest Americans.

The Republicans on the Committee on Energy and Commerce have put forward a package that attempts to meet Reconciliation targets primarily by making cuts to the Medicaid program. These cuts would hurt the poorest of the poor, taking away needed healthcare services and raising the costs of care for the most vulnerable. According to preliminary estimates from the Congressional Budget Office (CBO), cuts directly affecting beneficiaries through higher charges or reduced services are three times higher than other cuts to the program under the Medicaid subtitle.

These cuts to the program that provides health insurance to one in seven Americans are being made to partially offset additional tax cuts for the wealthiest individuals. Households with incomes of more than $1 million a year – the richest 0.2 percent of the U.S. population – are already receiving tax cuts averaging $103,000 this year, and will receive another $20,000 a year in tax cuts when cuts coming in January are fully phased in. And, nearly all (97 percent) of the new measures benefit households earning over $200,000 a year.[1] It is particularly disturbing to see the Committee move forward with this package while American families continue to lose health insurance coverage and slip into poverty.

The number of Americans without health insurance was at an all-time high in 2004 – an increase of 800,000 people from the preceding year. Six million more people had no health insurance in 2004 than in 2000. Medicaid and State Children's Health Insurance Program (SCHIP) coverage largely protected children from this sobering downturn.[2] And, according to the most recent U.S.

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[1] Center on Budget and Policy Priorities, New Tax Cuts Primarily Benefitting Millionaires Slated to Take Effect In January, September 19, 2005.

[2] Center on Budget and Policy Priorities, The Number of Uninsured Americans Continued to Rise in 2004, August 30, 2005.

Census data, the number of people who work but live in poverty increased by 563,000 and median income among the working age population fell by 1.2 percent. There were four million more poor people in 2004 than in 2001.[3]

The Senate Committee on Finance Republican package, while flawed in its own right, did not cut beneficiaries' services, increase out-of-pocket costs, or increase long-term care penalties. The House Republican package included numerous harmful provisions that the Senate Republican did not adopt.

Rep. Edward Markey offered an amendment to strike all of the provisions in the Medicaid Subtitle. It was defeated on a party-line vote. The following highlights the major flaws in this bill.

Increased cost-sharing for all Medicaid beneficiaries

Subtitle A of Title II increases cost-sharing for all Medicaid beneficiaries. First, it increases the nominal cost-sharing amounts that are allowed to be charged under the law, and indexes those amounts to medical inflation. If this provision is enacted, the cost-sharing charges will increase on average six times faster than the Federal poverty level (FPL), which is indexed only to inflation. The package would expose Medicaid beneficiaries to new premium requirements, which could reach 5 percent of income, even for a family at 101 percent of FPL (just over $1,031/month for a family of 2). No beneficiary with an income greater than 100 percent of FPL is protected against premium charges; States could charge premiums as high as 5 percent of income.

Providers are explicitly allowed to turn patients away if they cannot pay the cost-sharing on the spot. In addition, States will be able to terminate coverage if they cannot afford premiums. States are not required to have a system to track cost-sharing and notify families who have reached the cap. Families will have to keep receipts and other items to prove to the State they have met the burden. Presumably, they would also have to carry these materials with them to medical appointments to prove to a provider that they are no longer subject to the cost-sharing requirements.

In addition, the bill grants broad new authority for States to determine income for the purposes of applying cost-sharing rules. Under current law, States have flexibility to disregard certain income and assets, however they can be no more restrictive than the Federal standard. States could now be *more restrictive* and thus count additional income, such as an unrelated party living in the home or a non-legally responsible stepparent (increasing gross income) to apply higher cost-sharing burdens at lower levels of poverty.

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[3] Center on Budget and Policy Priorities, Economic Recovery Failed to Benefit Much of the Population in 2004, August 30, 2005.

While certain services are exempted from cost-sharing, such as services for children in families with incomes under 100 percent of FPL, prenatal services furnished to pregnant women, preventive services, and services furnished to individuals in institutions, due to the new premium requirements and other cost-sharing requirements on prescription drugs and emergency room access, the protections for these populations on paper will mean little in practice.

Second, the package includes new cost-sharing requirements on prescription drugs and emergency room visits. These requirements would apply even to children and pregnant women under 100 percent of poverty who under current law are exempted from cost-sharing. States would be permitted to charge up to three times the new nominal cost-sharing levels for "non-preferred" prescription drugs - up to $15 or 15 percent of the cost of the medicine. For children below poverty, States can only charge up to the "nominal" levels, however, this is a significant change from current law which protects children under poverty from cost-sharing. In spite of the fact that States may not charge cost-sharing higher than that charged under TRICARE, that program allows up to 50 percent coinsurance on prescription drugs, so this protection is meaningless.

Research has documented the detrimental effect prescription drug cost-sharing can have on health. A recent small survey in Minneapolis's main public hospital showed the negative effects of prescription drug co-payments implemented in that State's Medicaid program. Slightly more than half of those surveyed reported being unable to obtain their prescriptions at least once in the last six months because of the co-payment charges. Those who failed to obtain their prescriptions at least once experienced an increase in subsequent emergency room visits and hospital admissions, including admissions for strokes and asthma attacks.[4]

On emergency room use as well, beneficiaries will see higher cost-sharing burdens. Ostensibly, this is to deter non-emergency care. In order to deter unnecessary use of the emergency room, however, beneficiaries must have an alternative provider available. The bill would impose higher cost-sharing on Medicaid beneficiaries for non-emergency use of the emergency room, without ensuring adequate access to alternative services. In particular, the nature of the Medicaid population requires that special considerations be taken into account such as the location and hours of operations for alternative providers must be accessible, and access to appropriate language expertise (translator services). Many beneficiaries are constrained as well by not owning a car, and often the emergency room is the only healthcare provider accessible by public transportation when the individual is not working and can go. The bill, however, makes no requirement that States establish appropriate alternate care networks that can serve the affected population before such additional costs are imposed.

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[4]Melody Mendiola, Kevin Larsen, et al., "Medicaid Patients Perceive Copays as a Barrier to Medication Compliance," Hennepin County Medical Center, Minneapolis, MN, at http://www.hcmc.org/depts/medicine/medresearch.htm.

These new cost-sharing burdens would especially disadvantage those with disabilities, particularly those who are living in the community or attempting to gain independence and move from an institution into the community-based living arrangements. Those living with disabilities, even those at the lowest levels of poverty, are not protected from these new charges unless they reside in an institution. The practical effect of this package will be to exacerbate the institutional bias, forcing more individuals with disabilities out of the community and back into nursing homes and other institutions as they will be unable to pay the higher cost-sharing imposed on individuals residing in the community.

Reduced benefits coverage

Subtitle A of Title II also would allow States to provide significantly reduced benefits coverage for Medicaid beneficiaries. This coverage would mirror private coverage or coverage provided in the SCHIP, or be actuarially equivalent to that coverage. Medicaid does, in fact, cover benefits that are frequently limited or excluded in private insurance programs because of the nature of the population Medicaid serves. Those with modest incomes and those with intense healthcare needs find private insurance inadequate, either because the out-of-pocket costs are so great as to be a barrier to gaining access to care or because the benefits are insufficient. In particular, Medicaid covers prescription drugs, rehabilitation and therapy services, durable medical equipment, long-term care, and mental health services that are often unavailable in the private market.

The Republican package would allow States to offer benefits packages that do not include these important services. In addition, the package would eliminate the Early Periodic Screening Diagnostic and Treatment benefit (EPSDT) for children above the poverty level (100 percent FPL for those over age 6; 133 percent FPL for infants to age 6). EPSDT is of critical importance for all children and guarantees that they get treatment for identified medical problems that are medically necessary.

States could even apply these new, reduced benefits packages to individuals living with disabilities, again exacerbating the institutional bias. When individuals with disabilities find the benefits they need -- such as personal care services, home health services, or mental health services -- are no longer available in the community, they will be forced back into institutions.

Restrictions on access to long-term care

According to the Congressional Budget Office, the bill cuts $2.5 billion from long-term care services for the elderly and disabled who are living in institutions. By changing the "look-back" period and penalty date for asset transfers, the Republican package would impose significant new hardships on those who need long-term care services under Medicaid. These provisions will be especially troubling for individuals with cognitive impairments who will find it more difficult to maintain records or track financing 60 months back. These provisions will also result in destitute individuals being denied Medicaid eligibility when they need nursing home care at the point

when they have no other resources with which to pay. In addition, the package does not provide specific exceptions for legitimate "good Samaritan" transfers, for example to help a child with healthcare bills or donations to a charity.

In addition, the bill includes a number of other troubling proposals such as: a proposal to change the way income and assets are counted that would reduce the amount of income available to the community spouse after the death of the institutionalized spouse; a proposal pertaining to annuities and aggregating transfers that would place the burden on the beneficiary to prove that a transfer was for fair market value; and a proposal that would require Medicaid to count "entrance deposits" for care in a continuing care retirement community (CCRC) as an asset, to allow the CCRC to collect higher private-pay rates for care for a longer period of time.

If this bill is enacted, many elderly individuals would be forced to sell their house or take out a reverse mortgage in order to qualify for Medicaid. This proposal amounts to an estate tax on the elderly, disproportionately affecting minorities and low-income homeowners who hold notably more of their net wealth in the form of home equity. Homes make up more than 50 percent of total net wealth of minorities, and more than 75 percent of total net wealth for those with incomes under $20,000. Home equity is nearly 60 percent of net wealth for those over 75 years old.

In fact, Medicaid drains the estates of many more families than the estate tax. Medicaid beneficiaries assets are taxed at 100 percent above $2,000 or $3,000. In contrast, the effective tax rate on the very large estates of the wealthiest is only 5 percent (on the smallest estates subject to tax) to 23 percent (on the largest estates). The loss of Federal revenues from one year of the estate tax - estimated at more than $40 billion in 2005 - exceeds the entire amount spent by individuals and families out of their own resources for nursing home care - $33 billion in 2005.

Reductions in access to pharmacies

The Republican package would change the way Medicaid pays pharmacies for prescription drugs dispensed to Medicaid beneficiaries. The Inspector General of U.S. Department of Health and Human Services (HHS), the Congressional Budget Office, and the Government Accountability Office have identified the existing system as needing improvement. We support improvements to payment accuracy, but concerns were expressed that the new system established by this bill would be detrimental to pharmacies, in particular with an amendment adopted to include prompt pay discounts in the definition of Retail Average Manufacturer Price. These new reimbursement procedures could result in a lack of access to pharmaceuticals, particularly in rural areas.

Burdensome reporting requirements on beneficiaries and States

We also expressed serious concerns with a provision in the Republican package that would require that almost all Medicaid applicants provide paperwork demonstrating that they are United States citizens.[5] This provision essentially mandates that applicants — including children, those in institutions, homeless people and disaster survivors — submit either a valid birth certificate or passport to get health benefits. Large numbers of people do not have such documents readily available and the charges to obtain duplicate documents could be prohibitive, especially for those at the lowest income levels. This proposal is unnecessary and would create new administrative burdens for States. The HHS Office of the Inspector General recently investigated this subject and did not recommend requiring that states verify citizenship.[6] State Medicaid administrators noted that, based on the results of their quality control review systems, "they have not seen a problem with self-declaration of citizenship." The Centers for Medicare and Medicaid Services (CMS) acknowledged that it was not aware of problems of false allegations of citizenship. State administrators noted that requiring citizenship verification would slow down processing of applications and increase administrative costs. The requirements proposed in the bill would complicate administration, deny or delay insurance coverage for large numbers of U.S. citizens, and have negligible impact on the integrity of the Medicaid program. An amendment to strike this provision, offered by Rep. Hilda Solis, was defeated largely along party lines.

Health Opportunity Accounts

The Republican package included a provision allowing States to provide beneficiaries with "Health Opportunity Accounts" (HOAs) rather than comprehensive Medicaid coverage. These accounts would have a high deductible (including some Government help to meet the deductible), after which beneficiaries would pay ordinary Medicaid cost-sharing. HOAs would pose significant risks for beneficiaries, particularly those with high health care needs who exhaust their funds before having met the deductible. These individuals would face significant increases in cost-sharing. According to CBO, HOAs cost money to the Federal Government, rather than save it.

Medicaid beneficiaries already pay a significant amount out-of-pocket for their health care. On average, adults on Medicaid pay a larger percentage of their income in out-of-pocket medical expenses than do non-low-income individuals with private insurance. Moreover, in recent years, the share of Medicaid beneficiaries' income that is consumed by out-of pocket medical expenses has been rising twice as fast as their incomes. This burden is especially high for Medicaid beneficiaries who have disabilities.[7]

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[5]Those exempted include those who are applying as non-citizens and those who are eligible because of Medicare or SSI enrollment or those who have previously demonstrated that they are citizens.

[6]HHS Office of the Inspector General, "Self-Declaration of U.S. Citizenship Requirements for Medicaid," July 2005.

[7]Leighton Ku and Matthew Broaddus, "Out-of-Pocket Medical Expenses for Medicaid Beneficiaries Are Substantial and Growing," Center on Budget and Policy Priorities, May 31, 2005.

The Committee markup

An amendment (Markey) to strike the Subtitle on Medicaid failed on a party-line vote. Democrats offered numerous amendments on individual sections of the bill. For example, amendments were offered to exclude vulnerable populations from the legislation, such as: children (Capps); children with special needs (Waxman); members of the Armed Forces who served or are serving in Iraq and their families (Pallone); and women with breast or cervical cancer (Eshoo). Only the Eshoo amendment succeeded.

We also offered amendments to protect special populations from the increased cost-sharing or reduced benefits provisions by offering amendments such as: assuring meaningful benefits for individuals with disabilities (DeGette); protecting individuals with mental illness or cognitive impairment (Wynn); protecting low-income individuals from onerous premiums and cost-sharing (Baldwin); protecting special needs children from prescription drug cost-sharing (Davis of Florida); preventing enforcement of cost-sharing that would cause harm if services were not received (Waxman); protecting individuals with diabetes from increased cost-sharing (Gonzalez); protecting access to medically necessary services for children (Rush); and protecting access to benefits and preventing discrimination (Strickland). All of these amendments which would have protected vulnerable populations from the extreme provisions of this package were defeated largely along party lines.

Likewise, Republicans defeated Democratic amendments which would have protected the elderly from the onerous changes to Medicaid long-term care coverage, including an amendment to protect beneficiaries' homes (Schakowsky), an amendment to protect beneficiaries from losing access to nursing home care (Markey), and an amendment to protect the elderly from disqualification from Medicaid because of "good Samaritan" acts, such as helping a child with college tuition, donating to a charity, or keeping a family member from bankruptcy (Pallone).

Democrats also offered amendments to protect States from the Medicare "clawback" which, under current law, requires States to continue to pay prescription drug costs for beneficiaries eligible for both Medicare and Medicaid, even though the benefit will no longer be covered under Medicaid for these beneficiaries (Stupak, Strickland). The "clawback" has flaws that penalize States that have aggressively managed prescription drug costs under Medicaid and will cost States considerable resources in the coming years.

Rep. Stupak also offered an amendment to strike the provision that would cut millions from 4 States - Michigan, California, Pennsylvania, and Oregon - by eliminating the current law provision that allows States to tax Medicaid HMOs. States use this tax revenue to increase provider payment rates under Medicaid. Even the association representing the insurance plans subject to these State taxes, America's Health Insurance Plans (AHIP), was opposed to this provision in the Republican package This amendment was defeated on a party-line vote.

Notably absent from the bill were any provisions addressing important Medicare issues over which the Committee has jurisdiction, such as the pending Medicare physician payment cuts, Medicare overpayments to HMOs, problems with enrollment of the low-income into the new

Medicare prescription drug benefit, or other matters. Rep. Dingell offered an amendment to stave off the pending Medicare physician payment cuts for two years and protect beneficiaries from increased premiums as a result. This amendment also was defeated by a party-line vote.

Unlike the bill reported by the Senate Committee on Finance, which included an equal share of cuts to Medicaid and Medicare, along with increases in those programs, the bill adopted by our Committee cuts only Medicaid. Congress could save at least $20 billion in the next five years by eliminating overpayments to HMOs in the Medicare Advantage program. Unlike cutting benefits and increasing cost-sharing for the poorest of the poor, reducing HMO overpayments has been recommended by the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office, and even the HHS Inspector. Rep. Brown of Ohio offered an amendment that would have eliminated the cuts to Medicaid and instead reduced Medicare HMO overpayments, using the money saved to increase community living options for those with disabilities. The amendment was defeated on a party-line vote.

In sum, the bill shifts new burdens onto working families - through increased cost-sharing, decreased benefits, and new restrictions on access to long-term care - that will ultimately be detrimental not only to their health but to the health of our Nation as a whole. Rather than moving to reduce the number of uninsured and improve coverage for those who have it, this package moves us in the opposite direction. Savings achieved by reducing care for the most vulnerable will be used to partially offset new tax breaks for the wealthiest in the Nation, while the overall budget still increases the national debt. With the effects of this Subtitle on the health and well-being of infants, school children, their parents, individuals with severe and permanent disabilities, the working disabled, pregnant women, and the elderly weighing heavily on our minds, we strongly oppose these unfair and harmful provisions.

SUBTITLE B - KATRINA HEALTH CARE RELIEF

It has been two months since Hurricane Katrina and the long road to recovery continues. It is estimated that 1.5 million individuals survived Hurricane Katrina and they are now scattered across all 50 states with large populations going to Texas, Georgia, and Arkansas. The faces and stories of devastation, destruction, hope, and faith are scattered across the country. Both the States that Hurricane Katrina struck and the States where large numbers of evacuees have gone are now facing the bills of the hurricane and daily additional mounting costs of recovery and care.

With regard to health care, evacuees are in one of three categories. Either they have access to Federal or State health programs such as Medicaid or Medicare, they are still receiving services under private insurance, or are uninsured and either receiving care as needed from charity institutions or forgoing care altogether. Unfortunately, Medicaid, our Nation's safety net, as currently structured is unable to offer care for certain groups of people, such as single and married adults without children. For example, a 62-year-old man with diabetes would not be covered. Even though all types of people were affected by the devastation of the hurricane -- young and old, male and female, parents and single people -- only some are eligible for health care under Medicaid.

The Administration relaxed some of the bureaucracy to allow those that are eligible to apply or receive care without all of their documentation. They created new bureaucracies, however, in attempting to expand Medicaid to some within currently designated groups. They have established a system where each of the 50 States would need to separately apply for a waiver to gain approval for flexibility in the Medicaid program. None of the States, including Louisiana, Mississippi, and Alabama, would receive any additional financing for covering the survivors. And the host States would need to get reimbursement from the hurricane-devastated home States of Louisiana, Mississippi, and Alabama for the evacuee population receiving Medicaid coverage in order to be made whole.

The Administration's proposal did not address the fact that States need additional financial assistance in covering the many newly-uninsured populations and both home and host States need help with the State share of their Medicaid program to keep from cutting benefits. In addition, it does nothing to help providers with the free care they are offering. Congressional action is required for this type of comprehensive support.

The problem is exacerbated in Louisiana, Mississippi, and Alabama because of destruction and recovery costs. The revenue bases of these States have been eroded precisely as they need money to keep their States running. For example, Louisiana has a 11-14 percent unemployment rate and much of Mississippi's revenues were affected because many of the casinos were flooded. Without state money, it becomes difficult to keep the Medicaid program solvent. It also becomes impossible to retain or recruit providers and help them rebuild their offices and hospitals.

To date, neither the House nor the Senate have passed legislation providing funding for health coverage and provider assistance with bad debt.

Committee Bill

Rep. Pickering offered a substitute for the entire Subtitle, that was adopted by voice vote. The legislation, which provided insufficient resources to solve the entirety of the problem, included the following:

- The Federal Government will provide 100 percent Federal funding for Medicaid or SCHIP eligible individuals that reside in a Katrina impacted parish or county or for a Katrina impacted survivor wherever in the United States they may currently reside. The Federal Government will provide the funding retroactively starting on August 28, 2005, through May 15, 2006.

- A Katrina impacted survivor is an individual who had lived in a major disaster parish or county during the week preceding the Hurricane. And a major disaster parish or county is based on disaster declarations as of September 14, 2005, by the Stafford Disaster Relief and Emergency Assistance Act.

- The Federal Government will also provide 100 percent Federal funding for all Medicaid recipients in a Katrina impacted parish or county. This includes any parish in the State of Louisiana and any county in the State of Mississippi.

Green Substitute

Representative Gene Green offered a broader and more comprehensive health relief package. In addition to full Federal funding for Medicaid-eligible individuals regardless of where they evacuated, provided they came from a disaster relief parish or county, it expanded coverage to all poor and near poor children, pregnant women, individuals with disabilities, and poor single adults who are from disaster relief Medicaid parishes and counties. The legislation also addressed the growing trouble the States of Louisiana, Mississippi, and Alabama are having with coming up with the State share for their remaining Medicaid population. They did this by providing 100 percent funding for all Medicaid recipients in Louisiana, Mississippi, and Alabama. The Substitute had a number of provisions to help those with private insurance as well. Finally, it did also have direct assistance for providers.

Green withdrew the Substitute after a colloquy with Chairman Barton, in which the Chairman offered to continue to work on matters contained in the Substitute. The Green Substitute included the following:

Emergency Assistance to Disaster States

Louisiana, Mississippi, and counties under disaster declaration in Alabama will receive 100 percent Federal Medical Assistance Percentage (FMAP) from August 28, 2005, through December 31, 2006, for their Medicaid recipients.

Disaster Relief Medicaid (DRM)

- Coverage for residents and evacuees of counties and parishes under FEMA declaration of hardest hit areas (individual and public assistance disaster declaration) regardless of where they live now.

- Provides Katrina survivors with streamlined access to temporary Medicaid benefits in either the disaster-affected States or a host State.
- Provides 100 percent FMAP for benefits provided through DRM to the State hosting the evacuee for benefits provided that evacuee.

- Covers all populations regardless of categorical, resource, or residence eligibility requirements up to 100 percent FPL.

- Covers pregnant women and children regardless of categorical, resource, or residence eligibility requirements up to 200 percent FPL.

- Streamlined eligibility and enrollment procedures would apply, including common one-page national application form promulgated by the Secretary, no requirement of documentation, issuance of a temporary eligibility card, presumptive eligibility, and off-site enrollment.

- Individuals can self-attest to eligibility for DRM, but States are obligated to make a good faith effort to determine eligibility and individuals are liable for full costs of care if they falsely attest.

- Covers workers who live outside the geographic area but lost employment from a business located inside the geographic area as a result of Hurricane Katrina.

- Allows States to provide extended mental health benefits under DRM up to 100 percent FPL.

- Ensures that Home and Community Based Services (HCBS) populations in DRM do not count against host State Medicaid limits or caps.

Duration of DRM

- DRM would be a temporary Medicaid benefit eligibility that would last for an initial 5-month eligibility period, with a possible extension of an additional 5 months by the President/Secretary. Any determination of an extension of DRM eligibility by the President/Secretary will apply to DRM benefits nationally.

- The 5-month clock for benefits would begin on the date of enactment, with retroactive coverage of claims incurred by DRM-eligible individuals from August 28, 2005.

Amendment to Existing 1135 Waiver Authority

- Amends 1135 waiver authority to allow the Secretary to extend benefits under existing authority to individuals displaced due to a disaster. Current authority only allows the Secretary to waive requirements for a specific geographic location.

Emergency Assistance to Providers

- Creates a Disaster Relief Fund to offset increased Medicaid or uncompensated care costs arising for Medicaid providers (hospitals, skilled nursing facilities, Federally qualified health centers, rural health care clinics) as a result of Hurricane Katrina.

- Fully reimburses hospitals in disaster areas and for evacuees originating in disaster areas for Medicare bad debt (unpaid Medicare beneficiary co-payments and deductibles).

- Ensures hospitals in disaster areas are not penalized for any failure to submit quality data.

Emergency Assistance to Medicare Beneficiaries

- Waives the Part B late enrollment penalty for Medicare eligible beneficiaries who are unable to submit applications during the initial enrollment period.

- Requires the HHS Secretary to submit to Congress by December 1, 2005, a written plan on how CMS will transition into Medicare Part D the dual-eligibles who are evacuees or residents of hardest hit counties and parishes.

Emergency Assistance for Private Coverage

- Disaster Relief Funds may also be used to provide employee or employee and employer share of private insurance coverage for pre-existing coverage.

- Programs administered through State insurance commissioners.

Additional amendments

The Committee adopted an amendment offered by Rep. Burgess to exempt Hurricane Katrina evacuees and income attributable to such evacuees from consideration in the per capita income computation of the State's Federal matching assistance percentage for any year after 2006 if the Secretary determines the State has a significant number of Hurricane Katrina evacuees. It passed on voice vote.

Another amendment by Rep. Burgess, also adopted by voice vote, requires the Secretary of HHS to designate certain areas affected by Hurricane Katrina as medically underserved areas or health professional shortage areas and to designate one or more populations of each such area as a medically underserved population. We are not aware of any problem that is solved by the amendment. The Administration has provided numerous briefings for congressional staff on Katrina relief and has not indicated that legislation of this kind is either necessary or desirable. Moreover, the amendment contains unclear provisions that render it ambiguous in terms of its scope and duration. The National Association of Community Health Centers has expressed concerns with the amendment's waiver of important provisions applicable to providers that may otherwise qualify for the programs and policies that are implicated with designation of an area as a health professional shortage area or medically underserved area. It also noted that current law contains broad waiver authority. Chairman Barton recognized that Democrats had concerns with the amendment, and said they would be considered in conference.

SUBTITLE C - KATRINA AND RITA ENERGY RELIEF

Crude oil and gasoline prices had been rising steeply prior to the hurricanes. The findings in this subtitle discuss projections by the Energy Information Administration (EIA) of higher heating costs this winter, which will translate into greater cooling costs this summer. At a recent hearing of the Subcommittee on Energy and Air Quality, the EIA predicted winter heating prices may hit record levels, with natural gas bills up as much as 48 percent, heating oil prices as much as 32 percent, propane as much as 30 percent, and electricity as much as 5 percent.

Nevertheless, this Congress has failed to increase funding for the Low-Income Home Energy Assistance Program (LIHEAP) either through regular appropriations or emergency appropriations. This Subtitle adds $1 billion in spending for LIHEAP.

Representatives Rush, Green, and Markey offered an amendment to change the $1 billion spending to $3.093 billion. This amount, along with projected appropriations, would raise LIHEAP spending to the $5.1 billion authorized level in the Energy Policy Act of 2005. It was defeated on a party-line vote. Major oil companies, already recipients of significant tax and other subsidies under the energy bill, are now enjoying record quarterly profits, but those who are least able to bear the brunt of high energy prices in the months to come have not gotten what they were promised.