

VIA Electronic Submission

October 4, 2010

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2238-P2
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: CMS-2238-P2; RIN 0938-AP67, Medicaid Program; Withdrawal of Determination of Average Manufacturer Price, Multiple Source Drug Definition, and Upper Limits for Multiple Source Drugs

The National Association of Chain Drugs Stores (NACDS) is pleased to submit our comments to the Centers for Medicare and Medicaid Services (CMS) proposed regulation published on September 3, 2010 in the *Federal Register* (hereafter AMP proposed rule). The proposed rule would withdraw two provisions of the “Medicaid Program; Prescription Drugs” final rule (hereafter AMP final rule) published in the *Federal Register* on July 17, 2007; the provision pertaining to the definition of Average Manufacturer Price (AMP), and the provision pertaining to the calculation of Federal Upper Limits (FULs) for multiple source drugs. The proposed rule also proposes to withdraw the “Medicaid Program; Multiple Source Drug Definition” final rule published in the October 7, 2008 *Federal Register* (hereafter Multiple Source Drug rule).

NACDS represents 140 companies – traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate 39,000 pharmacies, and employ more than 2.7 million employees, including 118,000 pharmacists. They fill nearly 2.6 billion prescriptions annually, including the majority of Medicaid prescriptions.

NACDS commends CMS for issuing the AMP proposed rule. NACDS strongly believes the AMP final rule was fundamentally flawed, and implemented the Medicaid pharmacy reimbursement provisions of the Deficit Reduction Act of 2005 (DRA) in a manner that was inconsistent with congressional intent. NACDS and the National Community Pharmacists Association (NCPA) challenged the AMP final rule in a lawsuit in November 2007. A federal court identified several legal problems with the AMP final rule, and as a result the court halted implementation of the AMP final rule for the purposes of Medicaid reimbursement to pharmacies. Rather than continuing efforts to implement the flawed AMP final rule, we applaud the Agency for moving forward with withdrawing the provisions of the AMP final rule, as well as the Multiple Source Drug rule.

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We are committed to working with CMS on the implementing regulations pertaining to the Medicaid pharmacy reimbursement provisions of the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act, and the FAA Air Transportation Modernization and Safety Act. We offer these comments in the hopes of establishing a strong, collaborative partnership with the Agency, and the implementation of a Medicaid pharmacy reimbursement policy for multiple source drugs that maintains the strong link between community pharmacies and Medicaid patients.

Definition of Average Manufacturer Price, Retail Community Pharmacy, and Wholesaler

Federal law defines AMP as “with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to retail community pharmacies; and retail community pharmacies that purchase drugs directly from the manufacturer.” In addition to the definition of AMP, accurate definitions of retail community pharmacy, wholesaler, and multiple source drug are also critical to implementation of these provisions in a manner consistent with congressional intent.

PPACA, as amended by the Health Care and Education Reconciliation Act, provide CMS with clear guidance on the definition of AMP. Specifically:

AMP calculations should include only prices paid by wholesalers to the original manufacturers only for drug products the wholesalers distribute to retail community pharmacies, and prices paid by retail community pharmacies for direct sales by the original manufacturer. AMP calculations should not include prices paid by entities other than the original manufacturer, such as repackagers.

CMS should issue a new rule that defines “retail community pharmacy” in order to accurately implement PPACA’s definition of retail community pharmacy. For example, in the AMP final rule, “retail pharmacy” was defined to include mail order pharmacies. Inclusion of mail order pharmacies would result in the inclusion of sales and rebates which are not available to retail pharmacies. It is also inconsistent with the definition of retail pharmacy in other programs, such as the Medicare Part D program, which defines “retail pharmacy” as “any licensed pharmacy that is not a mail order pharmacy from which Part D enrollees could purchase a covered Part D drug without being required to receive medical services from a provider or institution affiliated with that pharmacy.” PPACA clearly excludes mail order, long term care, and other providers, defining retail community pharmacy as “an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices.”

CMS should also issue a new rule that defines “wholesaler” consistent with PPACA. In the AMP final rule, wholesaler is defined as “any entity (including a pharmacy, chain of pharmacies, or PBM) to which the manufacturer sells, or arranges for the sale of, the covered outpatient drugs, that does not relabel or repackage the covered

outpatient drug.” The definition of wholesaler is overly broad and inconsistent with federal and state statutes that define wholesalers as entities that are licensed by states as wholesalers and engage in “wholesale distribution.”

We urge CMS to adopt a more limited, realistic definition of wholesaler, and one that is consistent with PPACA as well as the Food Drug and Cosmetics Act. In future rulemaking to implement PPACA, an entity should be considered a wholesaler only if it is required to be licensed as a wholesaler, and is engaging in wholesale distribution when it purchases the drugs. Both the 340B and ADAP programs include this licensure requirement. In the case of chain pharmacy distribution centers, they are generally licensed as wholesalers in the states in which they are located.

Furthermore, future rulemaking should also make clear that the prices paid to the original manufacturer by repackagers and other entities listed in the definition of wholesaler should only be included in AMP calculations to the extent those entities distribute the drugs directly to retail community pharmacies.

PPACA, as amended by the Health Care and Education Reconciliation Act, specifically excludes certain transactions from AMP calculations.

- i. Prompt pay discounts.
- ii. Bona fide service fees, including but not limited to:
 - a. Distribution service fees
 - b. Inventory management fees
 - c. Product stocking allowances
 - d. Fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs).
- iii. Reimbursement for returned goods and associated costs.
- iv. Transactions with PBMs, MCOs, HMOs, insurers, long term care providers, etc.
- v. Manufacturer discounts provided in the Medicare Coverage Gap Discount program (section 1860D-14A of the Social Security Act).

NACDS strongly supports the policy that bona fide service fees be excluded from the calculation of AMP. A bona fide service fee pays for a bona fide service, so it does not reduce the cost of purchasing a drug. We do not believe the list of bona fide service fees in PPACA is exhaustive, nor do we support an attempt to list all specific bona fide service fees in the final regulation. This will allow for future flexibility and innovations to occur in a highly competitive marketplace. Manufacturers rely on wholesalers and others to perform various functions to allow their products to come to market in a safe and effective manner. It is unclear what types of services will be needed from wholesalers and pharmacies on behalf of manufacturers in the future. CMS should withdraw the definition of bona fide service fees in section 447.502 of the AMP final rule, as it is inconsistent with PPACA. Future rulemaking will be required in this area.

In addition, unlike section 477.504(g) of the AMP final rule which CMS has proposed to withdraw, in a new AMP rule CMS should ensure that the following transactions are not included in AMP calculations:

- i. Sales to patients.
- ii. Sales to physicians.
- iii. Sales to hospital pharmacies, clinics and affiliated entities.
- iv. Sales to other manufacturers not acting and licensed as wholesalers.
- v. Sales to surgical centers.
- vi. Sales to ambulatory care centers.
- vii. Sales to clinics.
- viii. Sales to dialysis centers.
- ix. Sales to other mental health centers.
- x. Sales to other medical outpatient facilities.
- xi. Sales to home infusion providers.
- xii. Sales to specialty pharmacies.
- xiii. Sales to home health providers.
- xiv. Sales to mail order pharmacies.
- xv. Sales and rebates to pharmacy benefit managers (PBMs)
- xvi. Fees paid to group purchasing organizations (GPOs).
- xvii. Nominal price sales to “any entity”.
- xviii. Rebates and discounts “associated with” these sales.
- xix. Sales reimbursed by certain third parties.
- xx. Sales to patient assistance programs.
- xxi. Sales to all other closed door pharmacies.

AMPs for Drugs Not Generally Dispensed by Retail Community Pharmacies

In addition to the changes in AMP calculations made by PPACA and the Health Care Education and Reconciliation Act, Section 202 of the FAA Air Transportation Modernization and Safety Act made further changes to the calculation of AMPs for certain prescription medications.

Under the changes made by PPACA, manufacturers can only include prices for drugs distributed to retail community pharmacies when calculating AMPs. However, Section 202 requires manufacturers to exclude non-retail community pharmacy prices from the calculation of AMP “...unless the drug is an inhalation, infusion, instilled, implanted, or injectable drug that is not generally dispensed through a retail community pharmacy.”

We understand that the purpose of Section 202 is to ensure that AMPs can still be calculated for certain drugs for the purpose of state rebate collections. However, AMP now has two purposes – use as a benchmark for rebate collection as well as a benchmark for pharmacy reimbursement. The inclusion of non retail community pharmacy sales in AMP calculations will result in the inclusion of discounts and rebates not available to retail community pharmacies, and will lower AMPs. These

lowered AMPs could result in the setting of FULs that will underpay retail community pharmacies for multiple source drugs.

There are several alternatives available to CMS to ensure the calculation of AMPs for these drugs do not result in the below cost reimbursement for retail community pharmacies. First, it is critical for CMS to clearly define when these prescription medications are “not generally dispensed through a retail community pharmacy.” Lack of clear guidance from CMS will result in an inconsistent policy, as each manufacturer will make its own interpretation.

NACDS believes a drug is not generally dispensed through a retail community pharmacy when 90 percent or more of unit sales are to entities other than retail community pharmacies. Therefore, if 10 percent or more of a manufacturer’s unit sales are to retail pharmacies, then the drug is generally dispensed through a retail pharmacy and non-retail sales and discounts should not be included in AMP calculations. CMS should provide a definition of “not generally dispensed through a retail community pharmacy” in future rulemaking or other regulatory guidance, rather than leaving this determination to each manufacturer.

In addition to clear guidance from the Agency on the calculations of AMPs for these drugs, how and if these calculations are used in setting FULs is equally important. NACDS strongly believes that the FULs should be determined using prices paid by retail community pharmacies. Congressional intent in this matter is clear – the colloquy between the Senators that drafted the provision is attached. Therefore, when AMPs are calculated for certain drugs – such as inhalation or infused medications – and these drugs are not generally dispensed through a retail community pharmacy – then these calculations should not be used to determine FULs. The AMPs will be available for the determination of rebates, which we understand and support. However, since these AMPs will not be reflective of the prices paid by retail community pharmacies, they should not be used to determine pharmacy reimbursement. FULs are to be calculated when three or more therapeutically and pharmaceutically equivalent multiple source drug products are available for purchase by retail community pharmacies on a nationwide basis (PPACA §2503(a)(1)(B)). Since these drugs would clearly not be available in this manner, their AMPs should not be used to set FULs under the requirements of PPACA.

The ability of manufacturers to include non-retail sales in AMP calculations is limited to those drugs listed in Section 202 - inhalation, infusion, instilled, implanted, or injectable drugs. Whether a drug is not generally dispensed through a retail community pharmacy is not a consideration in the calculation of AMPs for drugs that do not fall into these classifications. CMS should provide clear guidance to manufacturers on this matter.

Finally, in providing clear guidance to drug manufacturers on the calculation of AMPs, we believe it is important to reverse the “adequate documentation” provision of the AMP final rule. See 72 Fed. Reg. 39142 (July 17, 2007). The provision states

that manufacturers should include all sales in the calculation of AMPs unless they have adequate documentation proving the sales should be excluded. PPACA clearly sets forth sales that should not be included in AMP calculations. Including this adequate documentation provision in rulemaking or other regulatory guidance would be in conflict with the intent of Congress in passing PPACA and inconsistent with current law. Instead, CMS should provide guidance to manufacturers that sales and discounts should be excluded from AMP calculations unless the manufacturers have adequate documentation to show that the sales and discounts fit the statute's definition of AMP.

When to Calculate Federal Upper Limits (FULs)

Since CMS also proposes to withdraw the sections of the AMP final rule pertaining to the calculation of FULs, additional rulemaking will be required to establish a process consistent with PPACA to determine federal upper limits. In the interim, NACDS believes CMS lacks regulatory processes that are necessary to make updates to the current FULs, such as a smoothing process and a process for determining nationwide availability of drug products. Any updates to federal upper limits should be suspended until CMS issues rulemaking on the calculation of FULs. In particular, AMP-based FULs should not be put into place until a new AMP rule has been finalized by CMS.

In order to be consistent with PPACA, future rulemaking should provide that FULs should be calculated only when three or more therapeutically and pharmaceutically equivalent multiple source drug products – rather than two or more, as required by the DRA - are available for purchase by retail community pharmacies on a nationwide basis.

PPACA is clear in this regard. CMS can only calculate a FUL if these minimum three products are available for purchase by retail community pharmacies on a nationwide basis. If only two equivalent products are available on a nationwide basis, then a FUL cannot be calculated. Similarly, after a FUL is set, if a drug shortage, product recall or other issue results in less than three products being available for purchase by retail community pharmacies on a nationwide basis, the FUL should be lifted. NACDS believes a drug product should be considered to be available on a nationwide basis if they are readily available for purchase by retail community pharmacies across the nation in sufficient quantities to supply the needs of the nation's retail community pharmacies. Products that are in short supply, or are marketed or sold by regional or niche manufacturers or suppliers should not be considered to be nationally available.

Furthermore, it is critical that CMS first issue a rule that creates a process for CMS to determine whether products are available on a nationwide basis. Consistent with PPACA, CMS should not just assume that all products are available nationwide and then place the burden of this determination on pharmacies, states, manufacturers, or others. In determining nationwide availability, a possible test may be whether the products are stocked by two of the three national wholesalers in sufficient quantities to supply most retail community pharmacies.

The AMP final rule's determination of what is "therapeutically and pharmaceutically equivalent" must also be revised. The FDA *Orange Book* refers to drugs that are equivalent as "A-rated" drug products. In contrast, drug products that the FDA "considers not to be therapeutically equivalent" are referred to as "B-rated" drug products. Nevertheless, the AMP final rule stated the CMS would apply FULs to "B-rated" drug products that are not equivalent to the drug products that were used to set the Federal Upper Limit; "we proposed that the FUL will be established, as per section 1927(e)(4) of the Act, only using an "A" rated drug. However, we proposed to continue our current practice of applying the FUL to all drug formulations, including those drug versions not proven to be therapeutically equivalent, (for example, B-rated drugs)." AMP Rule Preamble, 72 Fed. Reg. at 39155.

FULs are to be calculated based on three or more therapeutically and pharmaceutically equivalent multiple source drugs available for purchase by retail community pharmacies on a nationwide basis. After a FUL is set, it should be used to determine the reimbursement for A-rated drug products. Drugs that are B-rated are not therapeutically equivalent, and therefore should not be subject to the FUL.

Amount of Federal Upper Limit

In order to be consistent with the requirements of PPACA, future rulemaking should indicate that the FUL for each multiple source drug be calculated at no less than 175% of weighted AMP based on national sales utilization for all the nationally-available equivalent multiple source drug products.

We also recommend a smoothing process similar to that adopted for the calculation of ASP for lagged discounts. A smoothing process will help prevent a sudden reduction in a manufacturer's AMP from month to month for a particular multiple source drug if a large amount of discounts are paid in a particular month, but have been earned over a period of time. Before reporting the AMP, the manufacturer should determine a percentage based on the most recent 12-month rolling average of legitimate lagged discounts for a particular multiple source drug. The percentage amount should be applied to the AMP calculated for that quarter.

The "no less than 175%" language of PPACA provides clear authorization to CMS to use a higher multiplier to determine FULs in all cases, or in specific instances. NACDS believes this is critical in ensuring pharmacies are not reimbursed at a level below their costs to purchase prescription drugs. As AMP has never been used as a benchmark for pharmacy reimbursement, it remains to be seen how often a higher multiplier may be needed. We do believe a method for determining when to exceed 175% should be established in future rulemaking. For example, even if AMP was smoothed using a 12-month rolling average of lagged discounts, we would expect reported AMPs to move sharply from month to month, particularly for generic drugs. In situations where AMPs plummet from month to month as a result of discounts being applied or other issues, CMS should use its authority to go above 175%.

A multiplier higher than 175% may also be needed in the case of the inhalation, infusion, instilled, implanted, or injectable drugs identified in Section 202 of the FAA Air Transportation Modernization and Safety Act. Again, NACDS strongly believes that any AMPs associated with these drugs should not be used in the calculation of FULs as they are not available for purchase on a nationwide basis by retail community pharmacies. However, if CMS would elect to include these AMPs in the calculation of FULs, this would provide a clear instance in which a higher multiplier would be necessary.

We also encourage CMS to have a formal mechanism to appeal FULs in certain cases, such as if the product does not meet the criteria for a FUL because the product is in short supply or there are no longer an adequate number of equivalent products to meet the criteria for a FUL, there are price changes in the market due to raw ingredient shortages or market consolidation, or if the product is generally unavailable at the AMP used to generate the FUL. In these cases the FUL should be updated more frequently than monthly.

Multiple Source Drug Rule

We appreciate the decision by CMS to propose to withdraw the Multiple Source Drug rule, as well as the provisions of the AMP final rule. In determining the availability of a multiple source drug to retail community pharmacies, the rule inaccurately indicated a drug would only need to be available “in a State” rather than “in the United States.” CMS should issue a new Multiple Source Drug rule that is consistent with the requirements of PPACA.

Conclusion

Thank you for the opportunity to share our views. On behalf of NACDS and its membership, thank you for the proposed rule to withdraw the provisions of the AMP final rule and the Multiple Source Drug rule. As you move forward with additional rulemaking, we look forward to working with you.

Sincerely,



Julie Helm Khani
Vice President, Public Policy

S6766

CONGRESSIONAL RECORD—SENATE

August 5, 2010

MEDICAID PHARMACY REIMBURSEMENT

Mrs. LINCOLN. I ask to engage in a brief colloquy with the distinguished Senate majority leader and Senator MURRAY as it relates to the intent of a provision in this legislation regarding average manufacturer price—or AMP.

Do I understand that the provision in section 202 of this bill is solely intended to ensure that Medicaid rebates are collected from the manufacturers of the particular drugs specified in the bill, that is inhalation, infusion, in-stilled, implanted, or injectable drugs not generally sold at retail pharmacies?

Mr. REID. Yes, the intention of this provision is to ensure that rebate dollars are collected for those particular drugs. Drug rebate dollars have long helped support state Medicaid programs and the provision will ensure an accurate calculation of AMP for the purposes of these drug rebates.

Mrs. MURRAY. I thank the Senator for engaging in a colloquy with Senator LINCOLN and me and would also like to clarify that this provision is in no way intended to impact reimbursement to retail pharmacies participating in the Medicaid Program. Is that the Senator's understanding?

Mr. REID. The Senator is correct. The Secretary should direct drug manufacturers to calculate AMPs for these drugs to allow States to collect rebates. In order to maintain pharmacy reimbursement at appropriate levels for these drugs, the Secretary should use the discretion that is provided under the Patient Protection and Affordable Care Act to calculate a Federal upper limit, FUL, at an amount that is at least 175 percent of the weighted average AMP for those covered outpatient drugs.

Mrs. LINCOLN. We would like to thank the leader for his clarification and shared goal of protecting access to critical drug therapies for vulnerable populations at retail pharmacies.

Mrs. MURRAY. I agree.

Mr. REID. I agree with the Senators on the importance of protecting beneficiaries' access to these drug therapies and the retail pharmacies that faithfully serve them. I thank the Senators for their shared commitment to this goal.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, I ask for the yeas on the motion to concur in the House amendment to the Senate amendment to H.R. 1586 with amendment No. 4575.

The PRESIDING OFFICER. Is there a sufficient second? There appears to be a sufficient second.

Amendment No. 4576 is withdrawn.

The question is on agreeing to the motion to concur in the House amendment to H.R. 1586, with amendment No. 4575.

The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 61, nays 39, as follows:

[Rollcall Vote No. 228 Leg.]

YEAS—61

Alakaa	Gillibrand	Nelson (NE)
Baucus	Goodwin	Nelson (FL)
Bayh	Hagan	Pryor
Boehner	Harkin	Reed
Bennet	Inouye	Reid
Bingaman	Johnson	Rockefeller
Boxer	Kaufman	Sanders
Brown (OH)	Kerry	Schumer
Burr	Klobuchar	Shahen
Cantwell	Kohl	Snowe
Cardin	Landrieu	Specker
Carper	Lautenberg	Stabenow
Cassey	Leahy	Tester
Collins	Levin	Udall (CO)
Conrad	Lieberman	Udall (NM)
Dodd	Lincoln	Warner
Dorzan	McCaskill	Webb
Durbin	Menendez	Whitehouse
Feingold	Merkley	Wyden
Feinstein	Mikulski	
Franken	Murray	

NAYS—39

Alexander	Crapo	LeMieux
Barraso	DeMint	Lugar
Bennett	Ensign	McCain
Bond	Ernst	McConnell
Brown (MA)	Graham	Markowski
Brownback	Grassley	Risch
Bunning	Gregg	Roberts
Burr	Hatch	Sessions
Chenbliss	Hutchison	Shelby
Coburn	Inouye	Thune
Cochran	Isakson	Vitter
Corker	Johanns	Voinovich
Cornyn	Kyl	Wicker

Mrs. MURRAY. Madam President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BENNET. Madam President, today I was proud to vote for final passage of the amendment offered by Senators MURRAY, HARKIN, SCHUMER and REID to the FAA authorization bill. This amendment brings long overdue good news to teachers and kids in Colorado and those worried about losing access to the health care they need. I was elated to see the Senate break through the usual gridlock and pass this important legislation.

The package will save thousands of jobs and protect health services for kids and vulnerable populations across Colorado and the country. During this savage economy that is hurting families all over our state and our country, as we work to get our ship righted, our kids and our schools should be at the top of our list of priorities.

If we are going to ensure that we leave more opportunity for our kids than we ourselves have had then we must remain committed to education—to set the table for our kids' futures; to prepare them for the competitive world that awaits them; and to enrich their lives with a better education than the one that was offered to us.

I have tried to be a leader in the fight for the Medicaid Federal Medical Assistance Percentage, FMAP, funding and saving teachers' jobs. I was an original cosponsor of the Keep Our Educators Working Act of 2010, introduced by Senator TOM HARKIN. In February, I also led a group of 43 of my Senate colleagues in submitting a letter urging the majority leader to provide States with an additional 6-month FMAP extension.

The Medicaid FMAP extension passed today by the Senate was crucial in the effort to keep public servants at work across the country. Without it, States would be forced to layoff tens of thousands of more teachers and other public employees, cut education funding even further, and further reduce payments to health care providers. More than 900,000 public and private sector jobs could be lost.

Colorado alone would lose more than \$200 million if the FMAP extension fell victim to Washington politics. Cuts could include eliminating state aid for full-day kindergarten for 35,000 children, eliminating preschool aid for 21,000 children, and increasing overcrowding in juvenile detention facilities, according to the Center on Budget and Policy Priorities. The education jobs funding would prevent the loss of between 2,000 and 3,000 teacher jobs in Colorado alone.

I am glad to see this package is paid for. However, I was very concerned about the House package which paid for teacher jobs in part by cutting education reform programs. I joined 15 of my colleagues in signing a letter requesting that we find other offsets to pay for this important measure. I am very pleased that we were able to avert the cuts to critical education programs and save teachers' jobs—all without raising the deficit.

Additionally, while I strongly support the measure, in no small part because it is completely paid for and does not add one dime to our deficit, I would like to raise a strong concern with one of the pay-fors in this package. A rescission of \$1.6 billion from the Department of Energy's, DOE, renewable energy loan guarantee program was used to help offset this amendment.

In Colorado this important program has helped foster tremendous growth in the clean energy economy. Just last month, President Obama announced a conditional loan guarantee for a solar manufacturing facility in my home state and there are dozens of job creating renewable energy projects across the country waiting for approval from DOE.

This rescission places \$15 to \$20 billion of private investment in clean energy investment in jeopardy. While I am constantly reminded that the Senate needs to make tough choices as we strive to be fiscally responsible, I am compelled to raise my objection to this offset. It is my sincere hope that, in the future, this Chamber, the House of Representatives and the administration will avoid tapping into what are already scarce clean energy investments to pay for what are admittedly important recession-stopping items such as the ones we approved today.

Mr. NELSON of Nebraska. Madam President, earlier today, I voted in favor of two motions designed to extend the 2001 and 2003 tax cuts. Let me be clear, I strongly support extending individual income tax rates. While I voted in favor of these motions to show