I yield to the gentleman from Texas [Mr. ARMEY], the distinguished majority leader, to announce the schedule for the rest of the day.

Mr. ARMEY. Mr. Speaker, I thank the gentleman for yielding to me.

Mr. Speaker, it is our intention today, as we are prepared to proceed on the rule for Medicare select, and then immediately after that, to move on to Medicare select. As the Speaker knows, this is very important legislation, and the timing is critical because of a deadline that must be met.

Following our completion of work on Medicare select, it is our intention to move on to the adjournment resolution, which needs a rule; so we will be doing the rule and then the adjournment resolution. Any other business scheduled for today is business that we can put over until after the Fourth of July work recess so that upon completion of the adjournment resolution, pending action in the Senate, we ought to be able to have completed our day's work. That ought to enable us to get our Members well on their way to their districts for the district work period by the scheduled 3 o'clock departure time.

Mr. GEPHARDT. Mr. Speaker, I would simply inquire of the gentleman, this obviously means that changes in committee assignments will be held until after the Fourth of July recess?

Mr. ARMEY. Mr. Speaker, if the gentleman will continue to yield, let me say, we would anticipate that action to take place sometime after 6 on Monday, the 10th.

As the Members might want to be reminded, we have tried to conclude the district work period by a return on Monday, the 10th, that would involve no votes before 5 on Monday, the 10th, to give that day to the Members for travel with a sense of security that they would not face a vote prior to 5 and have the opportunity to make their trip.

That being the case, we would not, since there seems to be a high interest in this matter of the committee appointment, we would not begin consideration of the committee appointment until after 6, probably, on Monday, the 10th. But we should, as I think we have indicated, expect that votes might begin as early as 5 on Monday, the 10th.

So we would do the four scheduled suspensions and then move on to the Medicare select—I am sorry, the committee assignment, International Relations, Appropriations, Resources, and so on as the week goes by. Monday night we will do the committee assignment after 6.

Mr. GEPHARDT. Mr. Speaker, I thank the gentleman.

PARLIAMENTARY INQUIRY

Mr. SOLOMON. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore (Mr. HASTERT). The gentleman will state it.

Mr. SOLOMON. Is it true that there will not be an intervening vote before we take up the rules, and Members do not have to stay in the well of the House?

The SPEAKER pro tempore. The Chair cannot anticipate what votes will come forward.

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Mr. Edwin Thomas, one of his secretaries.

CONFERENCE REPORT ON H.R. 483, MEDICARE SELECT POLICIES

Ms. PRYCE. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 180 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 180

Resolved, That, upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 483) to amend title XVIII of the Social Security Act to permit medicare select policies to be offered in all States, and for other purposes. All points of order against the conference report and against its consideration are waived. The conference report shall be debatable for one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce. The previous question shall be considered as ordered on the conference report to final adoption without intervening motion. Upon the adoption of the conference report, Senate Concurrent Resolution 19 shall be considered as agreed to.

The SPEAKER pro tempore. The gentlewoman from Ohio [Mrs. PRYCE] is recognized for 1 hour.

Ms. PRYCE. Mr. Speaker, for the purposes of debate only, I yield the customary 30 minutes to the distinguished gentleman from California [Mr. BEILENSON], pending which I yield myself such time as I may consume.

During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, time is of the essence. Once again, that is the basic principle underlying our consideration of legislation to extend the Medicare Select Demonstration Program.

In April, the Rules Committee reported a timely rule for H.R. 483. Today, we bring to the floor a rule making in order the conference report accompanying H.R. 483, with only hours to go before this valuable program is set to expire.

In 1990, Congress created the 15-State demonstration Medicare Select Program to allow Medicare recipients the opportunity of purchasing a Medigap managed care option. The project in those states is set to expire today, June 30, and unless Congress takes prompt action to renew it, the insurance benefits of nearly half a million senior citizens covered by the Medicare Select Program would be in serious jeopardy.

The conference agreement extends the Medicare Select Program for a period of 3 years. It also expands this option to seniors in all 50 States, and puts it on track to finally becoming permanent if the Secretary of Health and Human Services certifies that the program has met certain conditions.

In addition, the conference agreement clarifies that the definition of a State, for the purposes of this bill, includes the District of Columbia and the territories of the United States: Guam, Puerto Rico, the Virgin islands, and American Samoa.

In order to expedite consideration of this conference agreement in the House, and to ensure that seniors will have uninterrupted coverage, the Committee on Rules has reported a straightforward and fair rule for this very necessary legislation.

Specifically, the rule provides for 1 hour of general debate on the conference report, equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce.

The rule also stipulates that the previous question shall be considered as ordered on the conference report to final adoption without any intervening motion.

Under the rule, all points of order against the conference report and its consideration are waived. While the Rules Committee generally prefers to avoid handing out such blanket waivers, this waiver and the rule itself are necessary because of a potential violation of clause 3 of rule XXVIII (28), which prohibits the inclusion of matters in a conference report beyond the scope of matters committed to conference by either Chamber.

A question has arisen as to the apparent lack of definition of the term State in either the House or Senate-passed bills. As I mentioned earlier in my statement, the conference report contains a definition of States which includes the District of Columbia and U.S. territories.

The waiver granted in the rule is a precautionary step to ensure that passage of this critical legislation is not unnecessarily stalled by this particular provision or by any other unforeseen, yet potential violation contained in the conference report.

Members might be interested to know, also that this rule fully complies with the 3-day availability requirement for conference reports, as the report was filed on June 22.

Mr. Speaker, the conference agreement provides a reasonable balance to permit a very valuable, and successful program for our senior citizens to continue, while allowing us time to evaluate the program more closely before making it permanent.

Our colleagues should keep in mind that the Medicare Select Program provides seniors with another viable option to receive affordable medical care. Premiums under the select option have resulted in savings as high as 37 percent over traditional Medigap policies. By giving older Americans more

choices within Medigap, we give them the flexibility to choose plans which meet their own special or individual needs.

In closing, I would remind our colleagues that the sponsors of this legislation have made it very clear that the House needs to act on this bill before leaving for the Fourth of July district work period. The Medicare Select Program is only hours away from expiring.

More than 450,000 Medicare beneficiaries will be impacted if the Medicare Select Program is not renewed. The Senate adopted the conference report on June 26. This rule will enable the House do to its part for our senior citizens.

Mr. Speaker, House Resolution 180 is a fair, balanced, and responsible rule. It was approved unanimously by the Rules Committee last night, and I urge my colleagues on both sides of the aisle to give it their full support.

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

Mr. BEILENSON. Mr. Speaker, I thank the gentlewoman from Ohio for yielding time to me. I yield myself such time as I may consume.

Mr. Speaker, we support the rule which, as my colleague and friend on the Committee on Rules has pointed out, waives all points of order against the conference report and is necessary because the conferees added new material not included in the House or the Senate bill.

The addition is minor. That is why we agreed unanimously last night to this rule for the conference report.

The legislation we are about to consider under this rule would expand the availability of an experimental Medigap Program, known as Medicare Select, from 15 States to the rest of the country. The Medicare Select Program makes available to senior citizens a managed care insurance policy to fill in the gaps of Medicare coverage. It differs from other Medigap policies that require senior citizens to participate in the insurer's selected network of health care providers in order to receive payment for Medicare's cost sharing amounts.

There have been a number of substantial concerns raised about the operation of Medicare Select Programs. In its initial estimate of the bill, CBO noted that a preliminary study of this program by the Health Care Financing Administration found very little management of care by the insurers and no measurable cost savings to Medicare.

In addition, preliminary data for a subsequent study indicate that Medicare costs have actually gone up in eight of the States where these programs now operate. Many of us had hoped that we would be able to postpone final consideration of the bill until results of the subsequent study are available to the Congress sometime this fall. We would be in a better position to evaluate the usefulness and cost of this alternative program to the elderly who choose to participate in it. Nonetheless, we understand that the proponents of this legislation feel it is important to complete consideration as soon as possible to ensure that the beneficiaries currently enrolled in the program do not lose their coverage.

□ 1100

In addition, Mr. Speaker, the conference report extends the authorization for the program for only 3 rather than the 5 years included in the original House and Senate bills. It also allows the Secretary of HHS to discontinue the program at the end of 5 years, if it is determined that the program results in higher premium costs to beneficiaries or increased costs to the Medicare Program itself.

This issue of cost is, Mr. Speaker, of course one of the real major and regular concerns about Medicare Select. Our colleagues will fully discuss all of this during the debate on the conference report.

We have absolutely no objection to the rule reported by the Committee on Rules last evening for consideration of this conference report. We urge our colleagues to approve the rule so we may proceed with consideration of H.R. 483 today.

Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Michigan [Mr. DINGELL].

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

Mr. DINGELL. Mr. Speaker, this is a bad rule, it is a bad bill, it is bad legislation, it has been handled poorly, it is going to hurt the American people, it is going to raise the cost of Medicare, and it is going to be generally bad for the economy, the country, and the budget. Having said, that, Mr. Speaker, it is probably OK to proceed.

I would urge my colleagues to vote this rule down. I would urge them with equal vigor and diligence to vote down the legislation. The bill is being pushed more rapidly than information is available, and more rapidly than the committee or the House is being permitted to gather the facts about what the legislation does.

Initial information shows that Medicare has had its costs increased 17 percent on the average in States in which this Medicare Select Program has been made available. What that means is that senior citizens are getting less for more, and the Medicare system is getting billed more for less. This is a wonderful giveaway to the health insurance companies. It is being crafted in a fashion which defies good explanation.

The rule is needed today because the Republican leadership pushed this bill through the House without adequate thought, and then rushed it to a conference which did not deserve that honorable title between the House and Senate. We had a conferees meeting, which was scheduled for 5 p.m. one day last week. It was over at 5:01 p.m. Only yesterday did the Republican leadership become aware of the fact that they had a number of significant scope violations in a two-page bill.

Clearly slovenly legislation, slovenly legislative process is before this body. The issues presented in the statement of managers and in the offers passed back and forth between the House and Senate were presented as merely technical, but they were in fact highly substantive, and they will, for example, try to make gifts through these devices to the health insurance industry.

The result of this action is also to assure that the study which should take place to find out what is really going to happen under this Medicare Select Program will be so crafted as to make it very difficult to in fact obtain the necessary facts that the Congress ought to have, to know whether we ought to continue to extend this outrage, or whether in fact we ought to terminate it, as we indeed should.

The scope of the bill was expanded so that insurance companies can sell highly questionable policies not only in 50 States but in the territories and in the District of Columbia as well. I am certain that there are a number of guileless, unsuspecting elderly consumers in these locations that can be plucked for further advantage and further economic benefit to the health insurance industry.

Of course, the health insurance industry will profit mightily from this further largesse by this Congress under the Republican leadership at the expense of the taxpayers, at the expense of the budget, and at the expense of Medicare recipients.

The subjects of the GAO study in the bill was changed, so it will be more difficult for us to get GAO to present us with options for modifying the MediGap market, and therefore, to be sure that the seniors who switch out of these Medicare select policies can do so in a way where they can get back into a decent package of insurance.

Understand, this is insurance which does not go on a level basis, it starts at about $870 a year, if one is 65, but by the time one has reached 85, it is going to cost $2,300 or $2,400. Nobody is telling the senior citizens about that at all. Of course, the process here has been crafted so as to proceed with such blinding speed that no one will see that the senior citizens, the Medicare trust fund, the American people, are going to get skinned by this outrage.

Mr. Speaker, I urge my colleagues to vote against the rule. I urge them to vote against the bill. I predict that if this bill passes and is signed into law, we are going to find that Medicare is going to cost the taxpayers and the trust fund about an additional 17 percent. I tell the Members, they should put that in their book. They are going to have a chance to remember that when we review this legislation.

Ms. PRYCE. Mr. Speaker, I yield 1 minute to the distinguished gentleman from California [Mr. THOMAS], chairman of the Subcommittee on Health of the Committee on Ways and Means.

Mr. THOMAS. Mr. Speaker, I had not planned to speak, but I do want to put the statements of the gentleman from Michigan in context. He was one of the 14 who voted against the bill originally. There were 408 Members who supported it.

Mr. Speaker, on April 4 he sent out a Dear Colleague letter that said, ''Why the rush to bring H.R. 483 to the floor this week?'' He just in the well stated, ''Why the rush on moving forward with this legislation?'' June 30, today, is the expiration date for this program. I would think that is why the rush argument has been laid to rest.

As far as scope is concerned, we said it was going to be available to 50 States. The majority on the other side of the aisle, in their wisdom, decided to contest that; since the 50 States was extending it to the District of Columbia and Puerto Rico, as according to the Social Security Act, they were going to argue that was out of scope, so we simply went to the Committee on Rules to make sure that we could include the District of Columbia and Puerto Rico in the scope.

As to the GAO study, I think the gentleman from Michigan [Mr. DINGELL] knows that we do not need legislation to get a GAO study. A Member just has to ask.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from Maine [Mr. BALDACCI].

Mr. BALDACCI. Mr. Speaker, it is the height of hypocrisy for the majority party to pat themselves on the back for restoring the Medicare Select Program, when just hours ago they cut $270 billion from Medicare to help pay for tax breaks for the wealthy.

The Medicare Select Program is a good program. It is a program that pays the cost for sharing of Medicare beneficiaries if they go into a selected list of providers, but the Medicare Select Program is a supplemental program, and after today, it has nothing to supplement.

Medicare select is a worthwhile program, but this worthy program cannot begin to make up for the damage of the massive Medicare cuts made earlier. Medicare select is supposed to be the frosting on the Medicare cake, not the entire cake. A diet of frosting only is bound to make the stomachs of America's seniors upset. I know that is how I feel today.

GENERAL LEAVE

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

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Ohio?

There was no objection.

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

Mr. BEILENSON. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. STARK], the ranking member of the subcommittee.

Mr. STARK. Mr. Speaker, I thank the distinguished gentleman for yielding time to me.

Mr. Speaker, I rise in hopeless opposition to a rule that was crafted in the dead of night, and I rise to warn the American public. The gentleman from Michigan [Mr. DINGELL], who spoke a few minutes ago, was absolutely correct. This is terribly flawed legislation. This bill destroys a fairly good idea.

This bill has been introduced and written by former operatives of the health insurance industry. It deregulates supplemental insurance, and provides an opportunity for the worst shylocks in the health insurance industry to steal from the Medicare system and from our seniors.

Sitting right over there is a man who, within the past year, has received hundreds of thousands of dollars from the health insurance industry. He is a Republican Committee on Ways and Means staff person who drafted this bill for the health insurance industry.

Mr. Speaker, they are entitled to get payback for the huge contributions they made to the Speaker's campaign funds. That is OK. We know that goes on. However, I am telling the Members, Mr. Speaker, that what has happened here presages doom. If this kind of sloppily drafted legislation is how the Republicans think they are going to find a way to cut $270 billion out of Medicare, they would save everybody a lot of time by just moving to eliminate Medicare, because they will do it through stupidity, lack of experience, urgency to provide help to the people who have feathered their campaign nests, and with complete disregard for the seniors.

Mr. Speaker, the seniors who sign up for this in States where it is not regulated, and it is regulated in those States, it is regulated by no one except the good conscience of the insurance companies. Companies like Prudential, who have stolen billions of dollars from seniors, companies that are under indictment or have pled guilty and paid $300 million, $400 million in fines are the same companies who are going to take care of our parents, and indeed ourselves, under this plan. Do not buy into that.

Mr. Speaker, this is just a precursor of the Republican plan to destroy Medicare. We will hear about it after the recess. We will hear about taking $270 billion out of the most popular program, the most efficient insurance program in the country. It is being done at the behest of the health insurance companies by the Republicans. Members should vote against this rule in protest, and Members should vote against the bill.

Mr. BEILENSON. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas [Mr. GENE GREEN].

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

Mr. GENE GREEN of Texas. Mr. Speaker, I thank my colleague, the gentleman from California, for yielding me this time.

Mr. Speaker, I voted for the Medicare Select bill as it first came up, and now I intend to support the conference committee report. But I have some concern about it, in light of the big picture. That is what we need to look at today on this House floor. I hope the American people are looking at it, particularly those people who are senior citizens.

Mr. Speaker, the budget resolution was passed yesterday, planning $270 billion in cuts in Medicare, and at the same time providing tax cuts of $245 billion. I do not think it makes sense that today, the very next day, we have a conference committee report on Medicare Select, which supplements the same Medicare Program that was cut yesterday.

Those of us who support the HMO concept and managed care, still support the individual making that decision. However, with what happened yesterday and what will happen over the next few years, we will see that freedom of choice for our seniors and future seniors limited. It has not happened yet, but we are setting the stage for it, as we stand here.

I represent the city of Houston in Harris County. We have 286,000 seniors who receive over $1.5 billion in Medicare payments. A $270 billion cut nationally over the next few years will impact those seniors. Mr. Speaker, the Republicans seem to not understand that health care costs are going up, and they are going up because we are an aging population. To cut those seniors, the growth, as they say, will force them to go into more managed care and into Medicare Select like we are seeing today.

We are voting on the conference committee report that offers seniors hopefully the goal of more coverage under the HMO and more expansion, but the secret of the HMO concept for seniors is freedom of choice, their freedom of choice to go into it, not somebody in Washington, a bureaucrat or even their elected Members of Congress saying, ''You have to go to a Medicare Select plan.''

Mr. Speaker, let me repeat what we are talking about today. We will see over the next few years senior citizens being forced into the Medicare Select or other HMO programs, removing that freedom of choice as part of the way to save that $270 billion. That is what people need to understand. That is the fear I hear from my constituents at home.

Mr. Speaker, last Monday I was with a hundred senior citizens in the city of Houston. Some of them were in the Medicare Select or the HMO that is offered by a number of private contractors. Some of them were happy with it. However, they wanted to make sure it was their choice, not the choice of the U.S. Congress or that of some bureaucrat. We promised Medicare in 1965.

Frankly, if we waited for the Republican majority to provide for Medicare back then, it would not be here today.

□ 1115

I guess what I am concerned about is the forced cuts, Mr. Speaker, particularly in the budget bill passed yesterday with the change in the Consumer Price Index, and again in light of what is happening today with this bill.

We will see the Consumer Price Index readjusted to where the cost of living increases in Social Security will be reduced. That reduction, with the increase in Medicare expenditures, will cost senior citizens who are now receiving it, and again those who are growing into it, those 60-year-olds, those 55-year-olds who are looking forward to be able to have some type of security and having medical care when they are over 65.

I like the idea of Medicare select, Mr. Speaker, but I do not like the idea when we encompass everything together with the cuts we will see and the forced choices those people are going to have to make. I think that is what we need to be concerned about. I would hope over the Fourth of July recess and over the next couple of months and even over the next few years, because this will not happen today or tomorrow or next week, but it will surely happen with the budget vote yesterday to cut $270 billion out of the growth of Medicare.

Mr. Speaker, I hope that all of our Members remember that, when we vote for this bill.

Ms. PRYCE. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Connecticut [Mrs. JOHNSON].

Mrs. JOHNSON of Connecticut. Mr. Speaker, I just want to thank the preceding speaker for his support of Medicare select. There were 408 Members of this House that voted for it. I hope every one of those 408 Members will vote for it again, because this is an entirely voluntary alternative for our seniors. In the States where it has been available, it has offered them more care at a lower cost and been well-regulated by both the State and the industry and some Federal rules.

I also want to point out that as we reform Medicare, as we assure that Medicare will be there for our seniors and provide the quality of care that we have depended on Medicare for, we will over the next 7 years increase spending per senior in America from $4,800 on average to $6,700 on average. That is a one-third increase, a very solid increase in the face of declining costs in the health care sector. Our seniors are going to be well cared for.

While change is hard, if it is made with concern and in a responsible way, we can increase the money that we make available for senior care per capita throughout this Nation in an honorable way and one that supports the needs of retirees in this great Nation of ours.

Mr. BEILENSON. Mr. Speaker, I yield 3 minutes to the gentleman from North Dakota [Mr. POMEROY].

Mr. POMEROY. Mr. Speaker, it has been a contentious, partisan week in the House of Representatives, and much of the division has involved the Medicare Program. The budget passed by this House yesterday on a largely partisan vote imposes cuts of $284 billion that will be devastating to the program.

That will definitely mean higher out-of-pocket costs for seniors and less choice. I feel bad about that issue this morning and bad about the way the House resolved it and anxious about how those cuts will actually be put in place as we deal with the legislation that is before us.

It is sometimes difficult, then, to get on to other issues where there is in essence no partisan division, where it is a pretty clear and simple little bill that ought not have some of the rancor from earlier debates spilling over into it, but that is not precisely the case with the Medicare select extension before us today.

It passed the first time in the House of Representatives 408 to 14, most Democrats, most Republicans joining together in a rather unusual show of bipartisan support for a program. Why did that vote occur? Because I think the Members recognized that a program such as this, a voluntary way for seniors to opt for an insurance program that is going to give them a premium discount, that has had a successful run in the 15 States that have been allowed to run the Medicare Select Program, ought to be extended to the 50 States, ought to be given a 3-year extension so that the marketing of this program can begin in earnest.

I know something about this program. I was the insurance commissioner in North Dakota at the time it passed. I lobbied HHS to get North Dakota into the program because I believed in it. Ten thousand North Dakotans participate in this program. They get a monthly savings in premium amounting to 17 percent below those buying the Blue Cross/Blue Shield Medicare supplement that is not Med select.

Medicare select saves money. It negotiates discounts from the hospital and passes it on to the senior citizen. It also passes on any managed-care savings experienced in claims payment to the senior citizen purchasing the insurance policy.

What is wrong with this? Is this some sort of diabolical plot by the evil insurance industry? Certainly not. Certainly not. It is a simple little program, it works well, and we ought not take some of the bad feeling we have about some of the other discussions going on around here and bring it to this little issue. Medicare select should be passed. This House passed it once before, 408 to 14, and I trust we will again this morning.

Mr. BEILENSON. Mr. Speaker, I yield 7 minutes to the gentleman from Rhode Island [Mr. KENNEDY].

Mr. KENNEDY of Rhode Island. Mr. Speaker, I was among those who voted against it when it came to the floor last time, and I want to correct something that my colleague was talking about in terms of leaving it up to the States.

Maybe it was good for North Dakota, and I am sure my colleague, when he was an insurance commissioner, looked out for the consumers, but I can tell you the problem with having 50 different select plans, 50 different select plans regulated by 50 different States. It means that seniors in one State, like in my State of Rhode Island, if they have their Medicare Select MediGap plan and they go over to Massachusetts, it is a different plan. That, to me, does not sound like the proper approach to take to this when we are talking about needing comprehensive savings.

In addition, I just want to talk a little bit about this so-called increased choice. Under the guise of giving seniors increased choice, Congress is about to pass legislation that will in fact box them in. Yes, one more plan will now be available, but it is a narrow one and it is difficult, leaving many seniors in a potentially very risky situation. More choice do not simply mean better choices. For seniors who are considering the Medicare select policy, keep one thing in mind: This plan could be hazardous to your health.

When Medicare select came before us the last time, I supported an alternative that addressed the serious flaws in Medicare select. This amendment would have ended the problems with price rising with age, lowered the barriers that make it difficult and risky and dangerous for seniors to switch, and would have limited the extension until we know that this is a really good idea, because the jury is still out.

Let me just add, what this does it, it puts it into the insurance companies' hands and allows them to come up with the rating system. I have seen these Medicare select plans, because in my State I represent the fourth most elderly district in this country, and the senior citizens in my State are worried about this because they know better than we do what is coming down the road.

It means that they are going to be able to age-rate you. What does that mean? That means when you get older, they are going to be able to jack up the premiums, and because you are locked into this plan now, you are locked in for life.

You try to switch, and guess what: You are going to be paying all those preexisting condition prices, because another insurance company is not going to want to pick up because you may have had asthma, you may have had some kind of visiting nurse care you might have needed, and new plans are not going to want to touch you.

Why? Because they are not going to make money off of you. Because if you are sick, insurance companies do not want to cover you. That is why we have Government, because Government is going to regulate the private sector when it comes to insurance, to make sure that the private sector does not run roughshod over the senior citizens and take advantage of them.

Believe me, if you do not think they are going to do it, you have got another think coming, because these HMO plans are all about making money, and they do not make money off people who are sick. They do not make money off senior citizens.

Be careful, Members. Be careful when you vote for the select plan, because the Republicans did not allow enough time for us to do a proper study of this and now they want to open it up to all the States under the guise of new choice.

What is that new choice? It is a bait-and-switch routine. It says new choice. We do not want to face the tough choices, so we will let this private marketplace reduce your benefits. That is what we are saying.

We are squeezing the Medicare budget. We are seeing it on the floor of this House. We are squeezing Medicaid. We are cutting the senior citizens Medicare Program. The gentleman from Ohio [Mr. KASICH], the chairman of the Committee on the Budget, says we are not, that we are only reducing the rate of growth, but make no mistake about it, there is going to be less money in Medicare.

What is going to happen? There is not going to be enough money to go around, so the MediGap select policies, that is, the supplemental insurance that allows senior citizens to cover what Medicare will not cover, if Medicare does not have as much money as they had before, you better believe they are going to have to have more in the way of supplemental insurance to bridge the gap. Congress is passing this Medicare select because the Republicans are just about to pass all these cuts to Medicare.

Mr. Speaker, this idea that this is going to save you money, this is really tricky. If you join the HMO plan, you are not paying as much, so who would not want to buy into that?

But let me warn you, in policies that have already been issued under this Medicare select policy, once you are in the plan, it does not bar them from jacking the rates up on you. Now you are stuck because you are in the plan. You have signed your rights away as a consumer.

And guess what? Let's say your doctor leaves the plan and you want to go back to your doctor. Forget it. Under Medicare select you cannot do that, because if your doctor is not on the list of approved doctors, you are not going to get that doctor. Let's say you want to switch and follow your doctor. You cannot do that.

Then as far as the prices, initially you have got a lower price, but like I said earlier, they will jack the price up on you once you get older. Once you get older, they are going to be able to age-rate you.

Mr. Speaker, insurance commissioners in the various States may be able to look after the senior citizens, but I just think it is a really terrible approach. It is the kind of approach we have been taking to everything, give it back to the States, but on health care I think we are making a big mistake when we are trying to have a patchwork quilt.

It is going to be a spot, State-by-State approach to this problem, and I do not think it is the right way to go. We need comprehensive health care reform that regulates the insurance companies on the national level, because in a small State like mine in Rhode Island, these insurance companies are going to be able to run roughshod over us and we are not going to have a leg to stand on.

My State is a million people. Do you think we are going to be able to stand up to those insurance companies and say, ''Hey, what you're doing is wrong''? Forget it. We cannot do it. We have got insurance companies in our State who are already threatening to say, ''We're not going to write your automobile insurance anymore.'' I do not want that to happen to health care and it should not happen to health care.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan [Mr. DINGELL].

Mr. DINGELL. Mr. Speaker, I rise to direct a question to the manager of the rule. I note that in the last words in the rule, it says, ''Upon the adoption of the conference report, Senate Concurrent Resolution 19 shall be considered as agreed to.''

To what are we agreeing in this rule? Can anybody help me to know what is in Senate Concurrent Resolution 19? I think this is an important matter, because the Senate would not have passed a concurrent resolution on it unless it were important, but we are being asked to agree to this.

To what are we being called upon to agree? Is this something that was considered in the 1-minute conference which we had between 5:00 and 5:01, or was it some matter which was not considered, which now must be considered and added to the proceedings of this body?

□ 1130

Mr. DINGELL. Mr. Speaker, can the gentleman from Virginia [Mr. BLILEY], my good friend, tell me what momentous Senate concurrent resolution we are adopting in the rule and why we could not consider it out in the open and have everyone know what we are doing here?

Mr. BLILEY. Mr. Speaker, will the gentleman yield?

Mr. DINGELL. I yield to the gentleman from Virginia.

Mr. BLILEY. Mr. Speaker, I would say to the gentleman from Michigan [Mr. DINGELL] that it is right out in the open. That the Senate resolution merely conformed the title to what we are doing.

Mr. DINGELL. Mr. Speaker, I would ask the gentleman, is that because we were sloppy in the House or because the Senate was sloppy or because the conference was sloppy in the processing of legislation? I understand that the title is to be changed so that it no longer refers to an amendment to the Social Security Act, but it refers now to an amendment to OBRA; is that correct?

Mr. BLILEY. Mr. Speaker, if the gentleman will continue to yield, it is not the proper duty for us to question what the motives of the Senate were for doing what they do. But I did point out that the resolution does conform the title to the bill. That is done all the time.

Mr. DINGELL. With great respect for my colleague, what this shows is this is stupid legislation, further done with great speed and limited wisdom.

Ms. PRYCE. Mr. Speaker, I continue to reserve my time.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from California [Mr. FAZIO].

Mr. FAZIO of California. Mr. Speaker, I had not intended to speak on this, but I felt at this point that I would want to comment. The gentleman from Rhode Island [Mr. KENNEDY] raises what I think are generally concerns about the entire way the health insurance industry is regulated in this country and the problem with adverse selection and other factors that really can work against the interest of working people and seniors generally. There is not doubt that this body needs to address unfair insurance practices and the overall problems of our patchwork health care systems. Furthermore, I do not believe that debate over this measure should be mistaken for the broader debate that needs to take place over protecting and improving on our Medicare system. What is important to keep in mind is that this program has been a positive if small step, toward providing more MediGap options for seniors who can get additional benefits at no more cost.

Therefore, Mr. Speaker, I rise in support not only of this rule, but of expanding this effort to experiment with health maintenance organizations and other forms of managed care in all 50 states.

While all of the data on this program is not conclusive, in my state of California, this demonstration project appears to be working. Seniors have the choice of opting for managed care MediGap programs or they can stick with a more traditional fee-for-service type MediGap Program. It is their choice.

There is a high rate of consumer satisfaction with these plans. Last year Consumer Reports Magazine rated the top 15 MediGap insureres nationwide. Eight of them were from the Medicare

Select Program. And while we need more analysis, there are strong indications that the program could eventually keep costs down.

I must emphasize that this is not a carte blanche extension. Medicare select cannot become permanent if the Secretary of Health and Human Services determines that it costs the Government money, that it did not save beneficiaries money, and did not provide quality health care. And I think it is the responsibility of both sides of the aisle to make sure that all three of those criteria are met and that we back the Health and Human Services Secretary if she or any of her successors determine that we have failed to meet this criteria.

Mr. Speaker, I would hope that this Congress, while supporting this today, will pay attention to the data that results from these further experimentations. Medicare select is an important test case for the Medicare system.

Mr. BLILEY. Mr. Speaker, I rise in support of the rule waiving points of order on the Medicare select conference report.

The Medicare select program provides Medicare beneficiaries with a cost effective alternative to typical MediGap policies. It gives seniors the option of purchasing a MediGap policy for hundreds of dollars less than the typical policy. Hundreds of thousands of Medicare beneficiaries benefit from these policies.

Medicare select policies, however, are sold through a demonstration authority which expires tonight at midnight. This conference report will extend the program and allow all States to participate in this excellent program which provides less costly MediGap policies to our Nation's elderly.

At this late date, however, our colleagues on the other side of the aisle were attempting to delay the continuation of this program by raising the most obscure and nitpicking objections based on scope violations. There are no real scope problems in this conference report. However, the Democrats in their effort to stop this program were resorting to technical nitpicking.

And who will be the individuals hurt if this program is stopped? The hundreds of thousands of elderly who have purchased these policies. I ask you to support this rule so that we can proceed to the consideration of the conference report. A vote for this rule is a vote for our Nation's Medicare beneficiaries, who can then gain the benefits of these innovative MediGap policies which provide high quality care at an affordable price.

Mr. BILIRAKIS. Mr. Speaker, I rise in support of the rule on the conference report on Medicare Select. I come to the floor with a strong feeling of deja vu. When I appeared on the floor to speak in favor of passage of H.R. 483 earlier this spring, I indicated how important the Medicare Select Program was and how the fate of half a million beneficiaries rested on the action taken by the House.

The road to this point, in my view has been unnecessarily long. If it were not for the action on the other side of the aisle, we would not be here at the 11th hour seeking passage of a rule to bring this 2 page conference report to the House floor. We have delayed long enough.

Medicare Select is a very simple program. It is a particular type of MediGap policy which allows seniors to choose a medicare benefits package modeled on a preferred provider delivery system of health care. The Medicare Select policy allows seniors to buy a less expensive MediGap insurance policy which wraps around the traditional medicare benefit. It represents the new wave of innovative managed care delivery options that the private sector is currently using to hold down the rise in health care costs. Let us remember that for those elderly who choose a MediGap policy, it is 1 of 11 options currently available.

I urge my colleagues to pass this rule so that we can enact this legislation swiftly. Our senior citizens deserve no less.

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

Ms. PRYCE. Mr. Speaker, I have no further requests for time, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

Mr. BLILEY. Mr. Speaker, I call up the conference report on the bill (H.R. 483) to amend title XVIII of the Social Security Act to permit Medicare Select policies to be offered in all States, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. HASTERT). Pursuant to the rule, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of Thursday, June 22, 1995, at page H6256.)

The SPEAKER pro tempore. The gentleman from Virginia [Mr. BLILEY] will be recognized for 30 minutes and the gentleman from Michigan [Mr. DINGELL] will be recognized for 30 minutes.

The Chair recognizes the gentleman from Virginia [Mr. BLILEY].

GENERAL LEAVE

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the conference report to accompany H.R. 483.

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

There was no objection.

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

Mr. Speaker, I urge my colleagues to join me in supporting the conference report to extend the Medicare Select Program. The conference report provides for a 3-year extension of the program. The report also requires the Secretary of the Department of Health and Human Services to conduct a study comparing the health care costs, quality of care, and access to services under Medicare Select policies with other MediGap policies. The Secretary is required to establish Medicare select on a permanent basis unless the study finds that (1) Medicare select has not resulted in savings to Medicare Select enrollees, (2) it has led to significant expenditures in the Medicare program, or (3) it has significantly diminished access to and quality of care. I think the bill provides for a reasonable balance that will permit a valuable and innovative program for our senior citizens to be continued while permitting a more informed evaluation of the program. We must remember that Medicare Select is a MediGap insurance policy which provides seniors with another option to receive medical care. By giving the elderly more choices within MediGap we give them the option to pick plans which meet their individual needs.

In my view, we must not allow this program to expire. It is unfair to both participants and insurers alike to have to worry about what the Congress will do next. Medicare Select is a small but important program, and I might add, a highly regulated program. It is regulated under the Federal MediGap standards. There are additional Federal statutory standards for select policies, plus our States' insurance departments regulate them under State law. Medicare Select saves senior citizens money, provides more choice for senior citizens than the current Medicare risk contract HMO, and has given them the opportunity to secure a more comprehensive benefits package. If we do not act to extend this program, no new enrollees will be permitted to enroll in select plans and we will see the ultimate demise of these plans. The end result is bound to be significant increases in premiums for current enrollees. Medicare beneficiaries will be denied a product that saves them money and which has served them well. There is no reason not to extend this program in a responsible fashion.

Mr. Speaker, I urge my colleagues to join me in supporting this conference report.

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

Mr. DINGELL. Mr. Speaker, I ask unanimous consent that my time be equally divided between myself and the gentleman from California [Mr. STARK], a member of the Committee on Ways and Means, and that he be permitted to control that time.

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 4½ minutes.

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

Mr. DINGELL. Mr. Speaker, the agreement we are voting on today extends the Medicare select demonstration program to all 50 States for a 7½-year period beginning in 1992.

It does so with no appreciation of the consequences of this. Although many support this program, I believe that because Medicare cuts required by the Republican budget in the amount of some $270 billion are so drastic, and

will require such fundamental reductions in the Medicare program, it is impossible to pass any Medicare legislation, including Medicare select without taking those reductions into account.

In addition, Mr. Speaker, as many of my colleagues know, we argued in the committee that we should await the results of the State evaluations before expanding this program to all 50 States. It has come to my attention that the preliminary results of this evaluation are now in, but they have not been made available by the handlers of the legislation.

Those results indicate that Medicare select is significantly associated with Medicare cost increases in 8 of 12 select States. Let me repeat that. Medicare select is associated with cost increases in 8 of 12 States.

Furthermore, the cost increase is 17.5 percent. The cost increase is 17.5 percent. That is not fiscal responsibility.

Now, while I know these results will not be final until next month, we should clearly examine the results before passing an expansion to all 50 States. How can we possibly extend a program that has the potential of increasing Medicare costs in all of the 50 States, as it has in the States in which it is now used by the amount of 17.5 percent?

This leads one to the unfortunate conclusion that my Republican colleagues are willing to cut back on benefits to Social Security recipients and to Medicare recipients, but that they are not willing to lock up a program which is going to increase costs to the Medicare system and to increase profits to the insurance companies.

Mr. Speaker, I therefore urge that we vote ''no'' on the conference agreement on H.R. 483, and that we reconsider these changes in the light of evaluation results and in the context of budget reconciliation. Then we can more fully examine the entire Medicare Program, which is going to be examined in extenso in connection with reconciliation, because we are going to have Republican cuts in Medicare recipients, and we should include the Medicare cost increases which will result in the additional beneficiary out-of-pocket costs that will occur under this program, along with increased utilization and limitations on the beneficiaries' choice of providers as indicated in the preliminary report.

Let me remind my colleagues that Medicare select has had some peculiar consequences. It has not been the unmixed blessing which the proponents would have us believe. First of all, it has raised costs, but it has done some other things which have significant impact on recipients.

It first of all starts out low and goes up. The average premium cost at the beginning is around $870 a year. But by the time the recipient has reached the age of 85, it has risen, lo and behold, to something like $2,300 a year.

Now, during that time he is locked in because any preexisting conditions which he had during the time or before he got on Medicare select, he cannot carry over and have treated in any new package. So if a person joins this Medicare Select Program, he is locked in. He cannot get out because he cannot get treatment for new conditions.

Those new conditions are carefully walled out by preexisting condition clauses in any new insurance policy. So he pays more and more and more and he cannot get out. If his doctor moves or his hospital closes or some condition requires him to want to go to a particular person, doctor, or facility for treatment and they are not included in this HMO, that individual cannot go.

This is Medicare select all right. It is selected for the benefit of the insurance companies who are going to make lots of money. And they are going to make it, in part, off the Medicare trust fund and they are going to make it in part off of the poor little guy who is dependent on Medicare for providing his benefits.

□ 1145

They are going to skin the public, and everybody is going to act with great surprise when we find the new returns and the new information show us that we have in fact cost ourselves a lot more money; we have in fact denied Social Security and Medicare recipients benefits; and we have benefited the health insurance industry; and we have left ourselves in a situation where we all of a sudden find that Medicare has cost a lot more.

I urge my colleagues, vote this down. Let us consider it in a more temperate fashion, and let us consider it when we can have a look at all of the things, including the cuts in Medicare benefits which are coming to the Medicare recipients courtesy of my good friends and colleagues on the Republican side of the aisle.

Mr. BLILEY. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. ARCHER], the chairman of the Committee on Ways and Means.

Mr. ARCHER. Mr. Speaker, I thank the gentleman for yielding and compliment him on his good work on this bill.

It is a good conference agreement that deserves the support of every Member of this House. The Medicare Select Program expires today if we do nothing.

Early in the session, we heard from Members who opposed this program, that there is no need to rush, that we are moving too quickly, and yet here we are only hours away from the program expiring and over 450 thousand seniors are still uncertain as to their fate under this important program.

The Senate has already passed the conference report by unanimous consent. The 408 Members of the House who voted in favor of extending the Medicare Select Program earlier in this session should support this conference report and send it to the President for his signature tonight. It is a simple, noncontroversial bill which extends to seniors across the country the opportunity to choose at their option a Medigap program that has proven highly successful, high quality, and cost effective, and contrary to comments that were made earlier a few minutes ago, the CBO scores this as revenue neutral to the Medicare Fund, and the opponents of this know that.

My thanks to all the members of the Committee on Ways and Means and Committee on Commerce who have made this legislation possible. I particularly cite the outstanding work of two members of my own Committee on Ways and Means, the gentleman from California [Mr. THOMAS] and the gentlewoman from Connecticut [Mrs. JOHNSON]. It was their energy and commitment that brought us to this point today.

Mr. Speaker, this is a worthy proposal. I urge an ''aye'' vote on the conference report.

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

Mr. Speaker, this conference report legislation seeks to extend and expand the capricious demonstration program which will endanger the Medicare program and its beneficiaries.

Basically it is a license for the insurance companies to steal.

Medicare is the finest health care program in the county. There is no insurance plan in the country that offers more beneficiary choice. It is valued because we in Congress have worked long and hard to make it so.

Today by forcing a premature expansion of this demonstration program, the Republicans in Congress are turning their backs on this great tradition. Republicans are putting the interests of private insurance companies ahead of the Medicare program, not only in this bill, but in their budget bill which seeks to cut $270 billion out of the Medicare program, and they are ignoring the beneficiaries who rely upon it for their health care security.

This bill, as I have said before, is written by a Republican Ways and Means staff member who, within the past year, was receiving hundreds of thousands of dollars from the health insurance industry. Talk about big time sellout to private interests, this bill takes the cake.

Medicare select will be presented as a program without problems, just another choice for the seniors to elect. The facts are quite different.

At the time of the committee action on this bill, only a very preliminary evaluation of the Medicare Select Program had been concluded. That preliminary analysis found as follows:

> There is little coordination or management of care by organizations offering Medicare Select. The network formed by insurance companies were initially organized to increase Medicare market share at network hospitals rather than to minimize utilization.

Since the time of the committee action, a more complete evaluation of

Medicare select has been conducted, and before my Republican friends dismiss the report as some partisan document, I would like to remind them that this report was commissioned by a Republican administration, and the researchers who conducted the study were selected by that Republican administration. The study has been ongoing for well over 2 years. I will enter the study in the RECORD, and it is important to note here that in the study it talks about costs and utilization findings to date. The study says:

We were surprised to find Medicare Select is significantly associated with Medicare cost increases in 8 of the 12 select States: Alabama, Arizona, Florida, Indiana, Kentucky, Minnesota, Texas, and Wisconsin. For the eight States indicating positive impacts on Medicare program costs, the average impact is 17.5 percent. The estimates vary from 7½ percent in Minnesota to a 57-percent cost increase in Indiana. However, only the Indiana estimate is much more than 20 percent. The results indicate that the cost increases substantially reflect increases in inpatient hospital utilization. These estimates are unusually robust.

That is the understatement of the day, 17.5 percent increase on the Medicare trust fund, in addition to cutting $270 billion out. As I have said before, you would save the taxpayers a lot of money if you just introduced a resolution to eliminate Medicare tomorrow, let the Republicans vote for it. That is basically what they intend to do. Let the public see their true colors.

Given the findings and the fact that the Congressional Budget Office found that this study raises serious questions about the operation of the Medicare Select Program, why are the Republicans rushing forward to extend and expand this demonstration project, particularly when they are trying to reduce Medicare expenditures? Are they that cavalier about the report's conclusion? For months congressional Democrats and the administration have called for a limited extension of the program in order that the assessment of the demonstration could be completed and necessary adjustments made based upon its findings. Republicans have only marched forward faster.

Why? Whose interests are the Republicans responding to in this intemperate bill? Why are we trying to reduce costs under Medicare, and this program at the same time is moving in exactly the wrong direction?

Halting the expansion of this demonstration program is the only prudent action for us to take.

Proponents of this bill have made the claim if we do not extend it beneficiaries will be harmed. That is wrong. It is absolutely not the truth. Everyone should understand there is no current participant in the Medicare select plan who will lose coverage if we do not extend the program today. Certainly, additional beneficiaries will be prohibited from enrolling after today, but current enrollees would be allowed to continue in the plans.

By voting ''no'' today, the program evaluation will be allowed to be completed without corrupting Medicare.

And, third, voting ''no'' today will confirm our responsibility for the fiscal integrity of Medicare by blocking a premature expansion of this program.

How can any of us explain to our constituents a vote to expand a program from 15 to 50 States that has just been found to raise costs to the Federal Government by tens of millions of dollars? That is fiscal irresponsibility at its highest.

For those who ignore the evidence and vote to expand this program today, before adjustments can be made to it, you are in effect voting to increase Medicare's costs by $800 for each beneficiary who ends up in one of these plans. That is not fair to the seniors.

Finally, what does the Medicare beneficiary get who is in the Medicare select plan? Access to a very limited network of doctors and hospitals. You prevent them from getting the ability to switch out of the Medicare select plan and back into a reasonable MediGap program. You deny them their choice of medical independence.

In my home State of California, the Medigap plan will cost them an extra $3,360 in premiums.

For the fiscal integrity of the Medicare trust fund and the protection of beneficiaries, you must vote ''no'' on the conference report to H.R. 483.

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

Mr. BLILEY. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida [Mr. BILIRAKIS], the chairman of the Health and Environment Subcommittee.

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

Mr. BILIRAKIS. Mr. Speaker, I rise in strong support of the conference report on H.R. 483, legislation to extend and expand the Medicare Select Program.

The Omnibus Reconciliation Act of 1990 was established by a Democratic Congress, under which insurers could market an additional Medigap product, an additional Medigap choice, known as Medicare select. Medicare select policies are the same as other Medigap policies except that supplemental benefits are paid only if services are provided through designated providers. The demonstration was limited to 15 States and expired December 31, 1994. The demonstration was extended through June 30, 1995, in the Social Security Act Amendments of 1994.

The conference report on Medicare select provides that:

First, Medicare select is extended to all 50 States for a 3-year period. The Secretary is required to conduct a study comparing Medicare select policies with other Medigap policies in terms of cost, quality, and access. Further, it provides that Medicare select will remain in effect unless the Secretary determines, based on the results of the study, that Medicare select has: First, not resulted in savings of premium costs to beneficiaries compared to non-select Medigap policies; second, resulted in significant additional expenditures for the Medicare Program; or third, resulted in diminished access and quality of care.

Second, GAO is required to conduct a study by June 30, 1996 to determine the extent to which individuals who are continuously covered under Medigap policies are subject to medical underwriting if they switch plans and to identify options, if necessary, for modifying the Medigap market to address this issue.

Select policies do not affect the obligation of Medicare to pay its portion of the bill. Beneficiaries who obtain covered services through one of the network's preferred providers will generally have their benefits paid in full. Under OBRA 1990, the select plan is also required to pay full benefits for emergency and urgent-out-of-area care provided by non-network providers.

Select policies do not remove a beneficiary's freedom to choose any fee-for-service provider. If a beneficiary is unhappy with a Medicare select provider for any reason, that person may opt out at any time to get off the plan and pick up any other Medigap policy, or he can remain in the plan and go to any provider, and Medicare will pay if it is a covered service. However, in that case, the beneficiary may be liable for a deductible and coinsurance.

An insurer marketing a select policy is required under OBRA 1990 to demonstrate that its network of providers offers sufficient access to subscribers and that it has an ongoing quality assurance program. It must also provide full and documented disclosure, at the time of enrollment, of: network restrictions; provisions for out-of-area and emergency coverage and availability; and cost of Medigap policies without the network restrictions.

In addition, Medicare select policies are governed by the same types of regulations imposed on Medigap policies concerning: limitations on preexisting conditions; loss ratios; portability; guaranteed renewal, and open enrollment.

OBRA 1990 also included significant penalties for Select plans that: Restrict the use of medically necessary services; charge excessive premiums; expel an enrollee except for nonpayment of premiums; or withhold required explanations or fail to obtain required acknowledgements at the time of enrollment.

The following are Medicare select demonstration States: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington, and Wisconsin.

As of October 1994, approximately 450,000 beneficiaries were enrolled in Medicare select; while the majority are covered through Blue Cross/Blue Shield plans, approximately 50 companies offer Medicare select products.

Current authority for the program expires in June 1995. Failure to extend the authority for the program would result in the inability of insurers to enroll new beneficiaries in Medicare Select Programs as of July 1995, although they could continue to serve current enrollees. This would lead to higher premiums for enrollees and the potential withdrawal of insurers from the market.

Is that what we want? It seems to me that none of our people want that. The gentleman from California has stated that Medicare select plans are not adequately regulated and has told us how terrible the plans are. Well, that is his opinion. Here are the facts:

The National Association of Insurance Commissioners [NAIC] has testified in favor of the program and stated that out of the 10 Medicare select States that report into the NAIC's Complaint Data System, there were only 9 Medicare select complaints last year.

The program has been a very good one for senior citizens. In August 1994, Consumer Reports rated the top Medigap insurers nationwide. Eight out of ten of the top-rated 15 Medigap plans were Medicare Select Plans.

It is a very popular program in my home State of Florida where some 13,000 Medicare beneficiaries are enrolled.

I urge my colleagues to support this legislation so we may continue to provide older Americans with an often needed and in my opinion, necessary option.

□ 1200

Mr. BLILEY. Mr. Speaker, I yield 1 minute to the gentleman from California [Mr. BILBRAY], a member of the committee.

Mr. BILBRAY. Mr. Speaker, I have to stand in support of the proposal, and I just want to point out to my colleague from California there is a 100,000 Californian seniors that want that choice. I have a stack, I have stacks of comments coming from my seniors in my district saying how it is nice to be able to have options that Washington is not mandating on seniors, that seniors are allowed to be treated as dignified individuals. This program was something that has worked, is continuing to work, in our State, and to restrict it not only from the rest of the country, but to allow it to die, is not a vote in support of seniors and their dignity, but actually a support to replace the dignity of seniors' choices with big centralized Federal control systems, and I think the problem is some of our colleagues are so wedded to command and control, big, centralized government that they are willing to sacrifice our seniors' ability to have the dignity of having their choice to choose something that serves them, and I think that we need to start treating our seniors with the dignity they earned over the years.

Mr. DINGELL. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from California [Mr. WAXMAN].

Mr. WAXMAN. Mr. Speaker, I rise in opposition to the adoption of the conference report on H.R. 483, a bill to permit Medicare select policies to be offered in all States.

Let me state that I oppose adoption of this conference report reluctantly. We have underway in a limited number of States, including my own State of California, a demonstration project to study the value and effects of Medicare select policies. I favor letting that demonstration continue. I favor continuing to offer Medicare select policies where they are currently being tested under the demonstration.

But I have grave concerns about expanding Medicare select to all States. At the time this bill passed the House I raised these concerns and suggested the prudent course would be to wait and receive the evaluation of the demonstration that was underway. We did not.

Now, before the conference was concluded, HCFA provided us with some preliminary information that the evaluation was finding. And that information should give pause to any prudent legislator. They found that Medicare select was significantly associated with cost increases in spending in the Medicare program itself in 8 of the 12 States where select policies were offered.

Surely, on a day when the Republicans in this House passed over the nearly unanimous objection of the Democrats a budget which slashes Medicare spending by $270 billion over the next 7 years, it is folly to pass legislation which threatens to increase the cost to the public of Medicare so that more private insurance companies can reap profits on their Medicare select policies.

It is only prudent to stop this expansion of Medicare select until we can be sure that they are not adding to expenditures in the Medicare Program.

We might also pause and consider the irony of the actions we have taken today. Let's think about why we need MediGap and Medicare select policies in the first place.

We need these policies for one simple reason: Medicare requires people to pay a lot of money out-of-pocket when they get sick. Most Medicare beneficiaries are so frightened by the amounts they have to pay if they get sick that they spend hundreds of dollars to buy MediGap protection.

And yet, as a result of the Republican budget this House adopted today, people on Medicare are going to have to pay a lot more.

Their MediGap premiums will soar—whether they try to economize by using Medicare Select or not. And if they just can't afford a Medigap policy any more—they will live in fear of having to pay a lot of out-of-pocket costs.

Some 4 million seniors under this Republican budget may find that they can't even afford to pay the higher premium to keep Medicare Part B protection at all. Once Medicaid is an underfinanced block grant program—which is what the Republican budget makes it—seniors can forget about any assurance of help from Medicaid to pay their Medicare premiums.

Remember, who the typical person is who relies on Medicare. Most Medicare beneficiaries have modest incomes of $25,000 or less. Nearly a third of them depend on Social Security for almost all of their income. And now they are going to find that this Republican budget means that half of their Social Security COLA is being eaten up by increased premiums and cost-sharing in Medicare.

We ought to be talking today about how to make Medicare better—about how to help people who can't afford the prescription drugs they need, who fear ending up in a nursing home that they can't afford.

Instead this House adopted a Republican budget that slashes the Federal commitment to Medicare and Medicaid. And we now are about to adopt a conference report which extends a program which might be costing Medicare money instead of saving it.

This is not responsible legislating. This is not putting the interests of Medicare and Medicaid beneficiaries first.

I urge rejection of the conference report.

Mr. BLILEY. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Connecticut [Mrs. JOHNSON], the principal author of this legislation.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from Virginia [Mr. BLILEY] for his leadership and hard work on getting this program before us for final action.

Mr. Speaker, I am very pleased to rise today in support of this final agreement to extend and expand Medicare select. This is the right kind of health plan choice for us to make available to all seniors in America at this time. Medicare select is a Medigap policy. That is it is just insurance covering costs and services that Medicare does not. The difference is the Medicare select enrollees get their care from a preferred provider organization, but they are still Medicare beneficiaries. Medicare will cover health care costs for them even if they go outside the network. By staying within the network beneficiaries make the best use of their coverage because the health plan picks up most or all of their out-of-pocket costs.

Medicare select is not, and I repeat, not, an HMO risk contracting plan. Such plans require beneficiaries to get their care entirely within the network or Medicare will not pay. With select, seniors in America have that choice to be part of an integrated system of care, but still go outside that system if they want to and if they choose to. Medicare covers their charges outside that network.

It is very important that, as we carry forward this debate and as we give seniors choices in America, they understand clearly what their choices are,

and so I want to make clear that my esteemed colleague from Michigan is not quite correct when he says that seniors would be locked into these programs. With due respect, in fact he is wrong. Any senior in this program, any Medicare Select System, can go outside that system and, as a Medicare beneficiary, can receive care under Medicare terms, but in addition any senior in a Medicare Select Program can change plans. They can drop this MediGap policy and pick up another MediGap policy, and in every single State in America there are MediGap policies on the market that have no exclusion for preexisting conditions that do not block any seniors out. In sum, in fact, the idea that any senior is locked into a Medicare select choice is simply not accurate, and that is important for seniors to know.

Medicare select also saves beneficiaries money. We know that seniors on fixed incomes have a tough time in this environment, and Medicare select saves them up to 38 percent premium costs.

Medicare select is not a Government program. It is an insurance program, and, as such, it is regulated at both the Federal and State levels. It operates around the Medicare Program, and in those States where it has been expanded, it is saving dollars.

In California with select the cost of medical services per admission is 20 percent lower than for nonnetwork providers. The average length of stay in a hospital is 73 percent lower than for nonnetwork providers, attesting to the management of care, the integration of care, and only one-third as many enrollees are ever admitted to a hospital from these integrated care systems, a great advantage for the elderly. A Washington State Medicare Select Plan operator has reported that Medicare select policies cost 13 percent less than the traditional insurance policy. Even after adjusting for demographic factors the plans realized a 5-percent savings to the Medicare Program.

Now those figures are about real experience. How does that real experience line up with some of the comments that my colleagues have made about the preliminary conclusions of the report that we, as Members of Congress, asked HCFA to do so that we can understand the strengths of this program and the weaknesses more fully?

This is basically how it boils out. That report is reporting very preliminary data. The researchers themselves say the results are inconclusive, but listen to what they say about those areas in which they have seen costs increase. The researchers suggest that under these managed care entities, that is the Medicare select plans, and I quote from the report, new patient screening has detected a large backlog of formerly undiagnosed and untreated problems. This has meant that new patients have unexpectedly large, albeit short-term requirements for medicare treatment. In other words, Medicare select plans are offering seniors far more careful, comprehensive analysis of their health care problems, and, yes, short term it costs more, and many of these plans that this report, this study, is reporting have only been in place 3 months, so we have only been through the high cost analysis and the early treatments.

In one of the States where the program has been in place since 1992, and they have 4 years of cost data, they are seeing significant savings. I ask, ''Isn't that just what we want? Don't we want early intervention? Don't we want prevention? Don't we want that backlog, the formerly undiagnosed and untreated problems, dealt with for seniors in America? And most importantly, don't we want seniors to have the choice, the voluntary choice, of that quality health plan?'' I, for one, do, and my constituents want this choice as well.

As a State that does not have a demonstration project, I get letters daily saying when are we going to have that choice. I urge my colleagues to adopt this conference report and to help us take the first step toward giving seniors in America better choices for their health care.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Speaker, I thank my colleague for yielding me this time.

Mr. Speaker, I support Medicare select and will vote for the conference report to extend this program to all 50 States. If it is properly structured, it can provide more competition, choice and cost savings. However I must tell my colleagues I am concerned that the study that was commissioned by HCFA shows that there might be increased costs associated with Medicare Select Programs in at least eight States which currently have the program. But what primarily concerns me: It seems like this Congress is acting or making decisions on what appears to be facts. When we look at the information we may be acting on what we believe to be correct rather than what the facts show.

□ 1215

Congress is taking as fact that Medicare select extends managed care into the MediGap marketplace and it will save money. Yet when we look at the study, that may not be in fact the case unless the Medicare select program is properly structured. Is this a preview of what will happen when we get to the budget debate?

In the near future we are going to be called upon to act on legislation to cut the Medicare program by $270 billion. Are we going to make these decisions on fact or beliefs? There are very limited ways in which we can reduce the Medicare program by $270 billion. We are going to be calling upon our beneficiaries to pay more, higher copays and deductibles, putting more pressure on the Medicare select program.

We are going to be asking our seniors who already as a class pay the highest amount of out-of-pocket costs, on average 21 percent of their income is used for out-of-pocket costs. If we are going to be talking about $27 billion in Medicare cuts, we are going to be asking our seniors to pay more in copays and deductibles. Will we be acting on our beliefs or on facts?

I am very concerned about that, Mr. Speaker, and concerned that we will not be looking at what impact those types of cuts will have on our seniors. I am worried that we are going to have to cut benefits. The Medicare program already does not cover prescription drugs and very little benefits for long-term care, really no catastrophic care. Yet we are going to be asked to make cuts in the program that could very well take away benefits from our seniors on the belief that that may be acceptable. I want to act upon fact.

We already have inadequate reimbursement levels and cost shifting within the Medicare system, causing in many areas our seniors to be jeopardized from receiving quality care. Are we going to be asked to make additional cuts that could very well cause more cost shifting and less adequate care to our seniors on the belief that that can be absorbed? I want to act upon facts.

The consequences of our actions will dramatically affect our Nation's seniors and their health care. It is imperative that we make these changes based upon the best data available, not just data that we choose to believe.

I hope in the future when we act upon Medicare that we do it upon the facts.

Mr. BLILEY. Mr. Speaker, may I inquire how much time remains?

The SPEAKER pro tempore. The gentleman from Virginia [Mr. BLILEY] has 13 minutes remaining, the gentleman from Michigan [Mr. DINGELL] has 4½ minutes remaining, and the gentleman from California [Mr. STARK] has 5 minutes remaining.

Mr. BLILEY. Mr. Speaker, I yield such time as he may consume to the gentleman from California [Mr. THOMAS].

Mr. THOMAS. Mr. Speaker, I thank the gentleman for yielding time to me. As chairman of the House subcommittee of the Committee on Ways and Means, we have looked at this over a period of time.

As a member of the conference committee, we produced a conference report. I am a little confused by the gentleman from Maryland's statement that we would want to base a decision as to whether or not we would go forward with the program on a permanent basis on facts rather than just assumptions or desires or wishes or hopes.

I can only assume that the gentleman from Maryland did not read the conference report, because I would join him, if, in fact, we were talking about creating a permanent program without a basis of analysis of a pilot program.

Despite what may have been from any of the speakers who are in opposition to this, all this does is continue a program until the Secretary determines that, in fact, there are savings, that this is a better program. If the Secretary of Health and Human Services, after a 3-year study, says that this is not saving money, it is not a better program, the program ends. If she finds it does, it goes forward.

So, first of all, the conference report says, we are going to take this pilot program that is in 15 States, make it available to 50 States, but not on a permanent basis. We are going to examine the results after 3 years. And then we will make a determination as to whether or not it is to be permanent.

We heard talk about a study over here. As a matter of fact, on the earlier pilot program, there was supposed to be a study reported to Congress in January. Six months later, it still has not issued a report. What they are talking about is a preliminary finding which was leaked by this administration.

We had the head of the Health Care Financing Administration in front of the subcommittee in which we said, you know, this seems to be a politically charged issue. We have folks who are taking extreme positions and making statements not based upon fact for whatever reason they choose to do so, and I am concerned about the political atmosphere.

So, Mr. Valdeck, please make sure that your operation does not prematurely leak information which may not have been fully evaluated about this program.

Mr. Valdeck in front of the Health Subcommittee said, you bet; we will make sure this information does not come out until it has been analyzed and properly understood and presented. Lo and behold, several weeks ago, initially on the Senate side and now we have heard statements read here that are supposedly flat-out statements of fact that this study shows that there are higher costs. In fact, that is not the case.

Mr. Valdeck apparently was so embarrassed by this that he wrote me a personal note saying that he was embarrassed that the study had gotten out prematurely, that it has not been vetted. They have not done the proper correlations in the study. Somebody is very interested in killing this modest little proposal.

Let us go back and remember what this is. Currently there are 10 programs available to seniors to augment their Medicare program. They are called MediGap. They are insurance programs that fill in where Medicare does not offer as complete a package as people would want. What we are doing is talking about adding one more, an 11th to the 10 that are already there, fully monitored by Health and Human Services. In fact, you have got to explain exactly what you are doing. You have to pass a standardized examination to make sure that you are doing what everybody else is doing. There are categories that have to be met. The seniors are fully protected and they have a choice.

It is not mandated. You choose. We are simply saying instead of 10 choices, we are going to offer 11 choices.

You would think that we are reinventing the wheel by offering seniors 11 choices rather than 10. All we are doing is saying that the 11th choice is of a kind of health care delivery service that more and more Americans find saving them money. That is what this is all about. These fellows over here who used to be the chairmen of the Health Subcommittee and Ways and Means, and the gentleman from California [Mr. WAXMAN] who spoke earlier was the chairman of the Health Subcommittee of Commerce, and the gentleman from Michigan was the chairman of Commerce, they are used to bottling up reform and change, especially the kind that had the private sector driving down costs in health care.

They are kind of frustrated because with this new majority, different people are in charge. We want to try these new ideas, fully protected with studies by the Secretary making a determination as to whether it goes forward or not.

So I understand their frustration. But in trying to deal with this frustration of being a new minority, you really ought to rely on facts rather than the kind of fear mongering and conjuring up of seniors deserted by their Government when you talk about the Medicare select program.

The gentleman from North Dakota was absolutely right. This is a modest little program. We think it will save money. Four hundred eight Members of Congress, both Democrat and Republican, voted for this the first time around; 14 voted against it. We have high hopes that the same 408 and perhaps some of the 14 who voted against this might join in in sending it to the President today so that on this last day of the pilot program the President will sign this bill so that the seniors will not be fearful that this option will not be available to them.

We are going to pass it today. I have high hopes the President will sign it tonight and then we will move on to more fundamental real reform where seniors will see that more choices will be available to them and that their Medicare dollar expenses will be covered by an ever-increasing amount from the Federal Government.

Those are the facts.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Montana [Mr. WILLIAMS].

Mr. WILLIAMS. Mr. Speaker, I thank the gentleman for yielding time to me.

The Medicare Select Program as a model deserves support, and it should be renewed. In fact, we should expand the model, but we should keep it as a model until we know how well in fact it is going to work and what the difficulties in it are. And we already have reports that tell us there are difficulties in it.

So, yes, we would like to see the program continued, but that is not what is going on here. This is a full-scale expansion of the program. We are not certain it works that well. And they want to put it, the Republicans do, in every State in this country. Now, why? and why today?

Because yesterday the Republicans voted to cut Medicare. I know they say they did not cut Medicare but, my senior citizen friends, inflation is going to continue in health care; right? Of course. And new people are going to come into the system, of course. Are they going to receive the same services that today's senior citizens receive on Medicare? No, because the Republicans are going to cut close to $300 billion out of what is needed to meet current services. So do not let them tell you they are not cutting the program.

This proposal being brought to the floor today is a duck and cover for yesterday's action of cutting close to $300 billion.

There is a second reason that they are expanding this program and that is because the lobbyists, including the health care insurance lobbyists, are in full throat and are writing legislation for the Republican leadership.

I chaired one of the subcommittees along with the gentlemen from California Mr. STARK and Mr. WAXMAN, that tried to reform national health care last time. And I learned something, I learned a lot, as chairman of that committee, as we passed out health care reform bills last Congress.

But I learned one thing that I will never forget and that is, you can trust some of the health care insurance industry some of the time, but you cannot trust all of them all of the time. This country has to keep one eye on the insurance company, and this bill takes both Federal eyes off of the health care insurance industry. And senior citizens will rue the day we did it.

Mr. BLILEY. Mr. Speaker, do I have the right to close?

The SPEAKER pro tempore. The gentleman from Virginia [Mr. BLILEY] has the right to close.

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

Mr. DINGELL. Mr. Speaker, how much time do we now have remaining?

The SPEAKER pro tempore. The gentleman from Michigan [Mr. Dingell] has 4½ minutes remaining, the gentleman from Virginia [Mr. BLILEY] has 7 minutes remaining, and the gentleman from California [Mr. STARK] has 3 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Michigan [Mr. KILDEE].

□ 1230

Mr. KILDEE. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I am deeply concerned about Medicare this year. First of all,

we know that the Republican budget will cut Medicare by $270 billion over the next 7 years. That certainly has to be taken into consideration in the context of this bill. This bill, while it may have some merit, the plan may have some merit, I do not think we should be expanding it as this bill would propose. The bill does allow insurance companies to sell insurance policies to seniors that limit their choice, and they may be locked into those choices.

Basically, Mr. Speaker, I fear that this year, this 104th Congress, we may see a series of things that will be weakening Medicare. First of all, this program itself is a pilot program. We should look at it more. One study indicates that it increases the cost about 17½ percent per beneficiary in 8 of the 12 States, and in only 1 State was there some possible cost savings.

However, put that in context again with what I mentioned in the beginning, that we are cutting $270 billion from Medicare. We have to cast this bill in that context. We are using that cut from Medicare to pay for a tax cut for our very rich.

Mr. Speaker, in my district, I do not see people asking for that tax cut, and especially, I think they do not want to take money from Medicare to pay for that tax cut. My mother died last year at age 84. In her life, both her mental health, her peace of mind, and her physical health was better served because of a good Medicare Program. We should approach this very, very carefully. Do not rob the account and do not expand this program without experience.

Mr. STARK. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Washington [Mr. MCDERMOTT].

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

Mr. MCDERMOTT. Mr. Speaker, this is a perfect example of the triumph of ideology over American pragmatism. The Republicans say they are going to save the fund. First they take $86 billion out by a tax break. Then they take another $280 billion out by the cuts they are going to make. Then their solution is to pick a solution that does not work.

There was a study done by the Research Triangle Institute which says it spends 17½ percent more for select than it does in the system we have today, which means they are going to spend it down quicker. The real result of their efforts is to get rid of Medicare. They want to break the system 17 percent faster by putting people into select. That is not a solution. It simply makes the problem worse. Everyone should understand it and vote ''no.''

Mr. DINGELL. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore. The gentleman from Michigan [Mr. DINGELL] is recognized for 2½ minutes.

Mr. DINGELL. Mr. Speaker, hurry, hurry, hurry. Let us get this bill through. Let us get it through before the facts are in. Let us get it in before it shows that this package for Medicare Select is in fact going to cost Medicare or the taxpayers more.

Hurry, hurry, hurry. Let us get it through before it shows that the senior citizen recipients of Medicare are not going to get the option to move from policy to policy on their health insurance packages which would supplement their Medicare policies; and hurry, hurry, hurry, before it comes out that a policy which costs about $870 is going to go up to something like about $2,300 by the time you get to 85, if you buy it for $870 at age 67. Mr. Speaker, let us get this thing through before the people find out what we are about. That is what my Republican colleagues are saying. That is what is at issue today.

What is good legislative practice and good legislation? It requires that we should wait and find out what the facts are. The information is already out. Medicare select is costing on the average 17½ percent more. That means that Medicare select is going to cost the Medicare trust fund 17½ percent more. It is going to trap senior citizens in policies on supplemental benefits that will not be able to be carried to new insurers because of preexisting conditions. Costs are going to go up.

Senior citizens are not going to know this at the time that their good-hearted insurance salesman comes around to peddle them this wonderful new Medicare Select. The taxpayers are not going to know that this is in fact going to cause the Medicare trust fund to go broke faster.

Hurry, hurry, hurry. Pass this thing before anybody finds out what is going on. Do it in a conference which takes less than 1 minute by the clock, and then have to be rescued by the Committee on Rules because such a poor job of legislation was done. Mr. Speaker, this is the way we are legislating today.

I would urge Members to vote this outrage down and let us proceed more cautiously. Let us protect the public. Let us see to it that senior citizens, the Medicare trust fund, and the American people get decent treatment here from this Congress today.

Mr. STARK. Mr. Speaker, I yield myself the balance of my time.

The SPEAKER pro tempore. The gentleman from California [Mr. STARK] is recognized for 2 minutes.

(Mr. STARK asked and was given permission to revise and extend his remarks, and include extraneous matter.)

Mr. STARK. Mr. Speaker, the reason to vote no on this bill is to give the Congress time to perfect the necessary structures and regulations for Medicare Select to work. Indeed, it does work in California. The trouble is, there is only one insurance company, Blue Cross, who has been importuning Members to support it, because the insurance commissioner will not allow it.

The corporation commissioner does, giving Blue Cross a monopoly. That is not fair in California, either. If it is good in California, let us let other insurance companies sell it. Somebody brought up the good name of the Consumers Union. They did in fact mention some of these policies. However, let me summarize Consumers Union's recommendations to the Subcommittee on Health of the Committee on Ways and Means in February of this year.

Consumers Union stated that:

Congress should study the impact of further negotiated discounts . . . before rushing to extend the Medicare Select program. . . . Research done to date indicates that the Medicare Select . . . has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings, but merely shifts costs to other consumers. Few insurers and few consumers have participated. In many States, regulation of this product has fallen between the cracks of different regulatory agencies—is it insurance or managed care?—leaving consumers without the protections they need. Congress should not expand the program and make it permanent, but should take steps now to fix what is broken, and what is broken is the pricing structure, the need for open enrollment, and await further study results before locking the program into place. With respect to Medicare Select, Consumers Union would urge you to proceed with caution.

I would join with the distinguished gentleman from Michigan [Mr. DINGELL] and others, and urge Members to vote ''no'' to protect the consumers, to protect the Medicare trust fund which the Republicans are going to dismantle and destroy, $1 billion here, $1 billion there, $84 billion to rich seniors, $270 billion to pay the tax cuts to the very richest in this country. Do not let them destroy Medicare any further. Vote ''no.''

SUMMARY OF CONSUMERS UNION TESTIMONY ON MEDICARE SELECT, FEBRUARY 10, 1995

Medicare Select is a cross between traditional Medicare supplement policies (''medigap'') and HMO's. We urge caution when it comes to expanding Medicare Select or making it permanent because of the following major problems:

Pricing games: Medicare Select policies often offer cheaper premiums to begin with. But because of a system of so-called ''attained age'' pricing that many policies use, premiums will rise steeply as the policyholder gets older. Congress should not lock-in or expand a program which perpetuates this deceptive pricing practice.

Illusory Cost Savings: Medicare Select premiums are often low, but at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that other medigap policies are designed to pay. But the hospital still has to cover its costs. The result: it shifts the cost to other patients—and their insurers.

The Medigap Maze: The whole idea behind the OBRA medigap reforms was to allow consumers to make kitchen table comparisons among plans. But the Medicare Select program doesn't forward that goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

We believe that it is premature to expand or make permanent the Medicare Select program. Preliminary analysis of the program

indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers. We recommend that Congress:

Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a statewide requirement of community rating for the medigap market.

Require a six month open enrollment period for all consumers who were previously enrolled in Medicare Select. (Currently, in many cases, they are not eligible if their Medicare Select insurer does not offer a traditional policy.)

Limit the extension of Medicare Select to a two-year time period that would allow for analysis of cost savings and quality control. Such a study is currently underway at HCFA. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

Consumers Union[1] appreciates the opportunity to present our views on the issue of Medicare Select. We have spent several years monitoring the medigap market and working to improve protections for seniors who buy medigap policies. We worked in support of this Subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA–90 medigap reforms. These reforms made it much easier for consumers to comparison-shop among so-called medigap policies, which are designed to fill in the gaps in coverage left by Medicare. We continue to believe that these reforms serve as a valuable model for future legislation in areas such as long-term care insurance and regulation of a supplemental market in future health reform.

This testimony addresses one aspect of the Medicare supplement insurance market—Medicare Select. Medicare Select is a cross between traditional Medicare supplement (or medigap) policies and HMO's. In return for initially cheaper premiums, consumers agree to obtain care within a designated network of doctors—in order to be reimbursed for the costs covered by the policy. (Medicare still provides coverage, regardless of whether the provider is in the Select network.)

We believe that there are several problems with Medicare Select. In the big picture, Medicare Select represents a diversion from the tough issue of reining in Medicare costs—through managed care or other steps. Pressing questions that this Subcommittee must address include: to what extent do HMO's—which limit seniors freedom of choice of doctor—truly save costs (or merely select the healthy risks)? Is there adequate quality assurance in Medicare risk contracts? Is there sufficient ability for consumers who do not feel well-served by Medicare HMO's to pick up traditional Medicare/medigap coverage? Is it possible—and fair to seniors—to ratchet down the Medicare budget without achieving cost control in the private insurance sector (in the context of overall health care reform)?

There are several major problems with the Medicare Select market and we urge caution when it comes to making Medicare Select a permanent program:

Pricing games: Medicare Select policies often offer cheaper premiums to begin with. But because of a system of so-called ''attained age'' pricing that many policies use, premiums will rise steeply as the policyholder gets older. Congress should not lock-in or expand a program which perpetuates this deceptive pricing practice.

Illusory Cost Savings: Medicare Select premiums are often low, but at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that other medigap policies are designed to pay. But the hospital still has to cover its costs. The result: it shifts the cost to other patients—and their insurers.

The Medigap Maze: The whole idea behind the OBRA–90 medigap reforms was to allow consumers to make kitchen table comparisons among plans. But the Medicare Select program doesn't forward that goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

Summary of Recommendations

We believe that it is premature to expand or make permanent the Medicare Select program because of these problems and others described below. Preliminary analysis of the program indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers. We recommend that Congress:

Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a state-wide requirement of community rating for the medigap market.

Require a six-month open enrollment period for all consumers who were previously enrolled in Medicare Select.

Limit the extension of Medicare Select to a two-year time period that would allow for study and analysis (that is currently under way by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

We elaborate on our concerns and recommendations below.

Analysis of the Medicare Select Market

Pricing games

Medicare Select policies often use an ''attained age'' pricing structure, which Consumer Reports says is ''hazardous to policyholders.'' Various letters and comments regarding Medicare Select have noted that Consumer Reports found that eight of the top 15 Medigap products were Medicare Select. But this tells only part of the story. Five of the eight policies mentioned use an attained-age pricing structure. Consumer Reports stated that:

Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable—just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the buyer of the New York Life policy would have spent a total of $5,000 more than the buyer of the United American policy.[2]

The attained-age pricing structure allows companies to bait consumers with low premiums in early years, and then trap them with high increases in later years. Standardization of the medigap market resulted in price conscious consumers, with the effect of facilitating a trend away from community-rated policies and toward attained-age rated policies. The percent of Blue Cross-Blue Shield affiliates, for example, that sell attained-age policies grew from 31 percent in 1990 to 55 percent in 1993.

Ten states have recognized this market dynamic and have taken steps to protect consumer either by requiring community rating for this market or by banning attained-age rating. These are Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington. Four of these states—Florida, Massachusetts, Minnesota and Washington—are part of the Medicare Select demonstration program.[3]

Recommendation: Require ALL states to do what several states have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a state's ability to participate in Medicare Select to a statewide requirement of community rating for the medigap market.

Illusory cost savings

The purpose of Medicare Select was to cut health care costs through coordinated care networks that increase the use of utilization review and management controls, often through PPO's. It was expected that enrollees would be restricted to a subset of providers. But the experience shows that often there is no restriction of providers. There is little coordination or management of care in Select plans.[4]

Medicare Select premiums may be low for the wrong reasons—because these policies shift costs to others by not covering all the costs that traditional medigap policies must cover. Medicare Select companies often negotiate with providers to eliminate the payment of Part A deductibles. Insurers have indicated that the discounts of the Part A deductible by participating hospitals is the most significant source of premium savings available in Medicare supplements.[5] This means that hospitals get less reimbursement from Medicare Select carriers. It does not mean that the hospital's costs are lower, so cost shifting to other patients (and their insurers) is inevitable.

Before extending Medicare Select to additional states (or for a substantial time period), we urge you to study further why Medicare Select premiums are often low. Are they cutting premiums for their policyholders merely by shifting costs to other payers? Another issue of concern to us is whether the Medicare Select markets in each state are truly competitive. We understand that in California, for example, there is only one key Medicare Select carrier (Blue Cross).[6] A study prepared for HCFA found that three-fourths of Medicare Select enrollees have policies from affiliates of three Blue Cross and Blue Shield plans (in Alabama, California and Minnesota), hardly an indication of a truly competitive marketplace.[7] We urge you to study the level of competition in this marketplace, recognizing of course that traditional medigap policies do compete with medicare Select policies.

Recommendation: Limit the extension of Medicare Select to a two-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional states until the studies are complete and regulatory adjustments can be put in place.

Medigap maze

A key goal of the medigap reform legislation that was included in OBRA–'90 was to provide true consumer choice of medigap

Footnotes at end of article.

policy by standardizing policies, thereby simplifying the choice. In light of the minimal role the Medicare Select products have made in this marketplace, we question whether the expanded complexity offers consumers significant benefits. Consumers (in Medicare Select states) must decide between Medicare only, Medicare risk plans, Medicare cost plans, health care prepayment plans, medicare Select plans, and traditional Medicare supplement policies. They can't even consider which of 10 standard packages to consider until they have made this choice.

Furthermore, insurers have indicated that the 10 standard medigap plans are appropriate for fee-for-service (traditional) medigap policies, but not for network Medicare Select products.[8] If Medicare Select necessitates an additional one or more standard policies, then simplicity is further undercut.

NEED TO AWAIT STUDY RESULTS

Medicare Select was included in OBRA–90 medigap reform legislation as a demonstration program. Medicare Select was established with the hope of achieving goals such as reducing health care costs (both for the Medicare program and consumers) and reducing the paperwork burden on consumers (since Medicare Select plans relieve consumers of the paperwork burden inherent in filing claims). It should not be made permanent until studies of its effectiveness have been completed. The preliminary report (February 1994) paints a picture of Medicare Select that is hardly complimentary. A tiny percent of people eligible have enrolled; a small fraction of insurers participate; cost savings appear to be superficial only and may be cost-shifting in disguise; the market is highly concentrated; Medicare Select regulation often falls between the cracks in state regulatory departments.

Some specific findings that should set off alarms to put on the brakes—not rush ahead with a permanent expansion—include:

Some states (e.g., Arizona) have found that market response has been poor and that beneficiaries tend to migrate back to traditional plans.[9]

Several states that were selected for the program could not get it off the ground and dropped out.[10] Others have had no applications for select plans.[11]

When studied by RTI, only 2.5 percent of eligible Medicare enrollees selected Medicare Select policies, and most of these ''rolled over'' from prestandardization products. It appears that consumers are not, in general, attracted to Medicare Select policies.[12]

Nor are insurers attracted to the Medicare Select product: only ten percent of HMOs and medigap insurers in Select sates offer Medicare Select policies, with even interest in some states.[13]

Recommendation: Congress should delay expanding and making permanent the Medicare Select program until further study results are available. It should not be made permanent without fixing the elements that are broken.

REGULATORY GAPS

Medicare Select is fraught with questions about regulatory authority. It is not unusual for a state's insurance department to regulate fee-for-service medigap coverage, but another state department (e.g, Department of Public Health or Department of Corporations) to regulate Select products. It is very possible that Medicare Select policies get lost in the regulatory cracks where authority for traditional insurance and HMO's is split. This confusion has even led to approval of plans (as Select) that deviate from the OBRA '90 standard plan designs.[14]

Medicare Select consumers need regulatory protection. For example, consumers switching out of Medicare Select need protection. Consumers who choose a Medicare Select option must use providers in the designated network in order to get medigap coverage. The NAIC model regulation provided protection to consumers who elect Medicare Select but then wish to change to traditional medigap policy. Companies were required to offer such consumers a policy with similar benefits, without underwriting. But this provision has a loophole—consumers have no assurance of such an offer if the Medicare Select company does not offer a traditional (''fee-for-service'') medigap policy.

In the event that Congress decides to end the Medicare Select program, either now or in the future, then consumers who have Select policies when the program is ended will need protection. Without new entrants in their pool, their premiums (in closed blocks of business) would spiral upwards. They will need the protection from such an open enrollment period.

Recommendation: Congress should require that all policyholders who wish to switch out of Medicare Select be eligible for an open enrollment period (regardless of which company they select) in order to protect them against being locked into a Medicare Select plan that they do not like.[15] This protection would actually help to promote the Medicare Select option because consumers would have a safety valve if they are dissatisfied. If Congress chooses to end the Medicare Select program, insurers should be required to extend an open enrollment period to Medicare Select policyholders. We urge the Congress to study carefully the regulatory experience and analyze where regulatory authority for Medicare Select is best housed.

DOES MEDICARE SELECT COMPROMISE QUALITY?

Medicare Select policies keep premiums low by negotiating lower reimbursement schedules with providers (mostly hospital), providing discounts to policyholders. On average Medicare pays doctors and hospitals about 59 percent of what private insurers pay for the same services. If (in the future) Medicare Select coverage is negotiated downward (e.g., providing Select policies with Part B discounts also), providers will get even less. At some point, the cumulative impact of lower reimbursement has got to have an impact on quality of care that patients receive. This could occur when providers withdraw from providing services to consumers, or when they cut corners (such as patient time) due to the lower reimbursement levels.

Recommendation: Congress should study the impact of further negotiated discounts for providers before rushing to extend the Medicare Select program.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings, but merely shifts costs to other consumers. Few insurers and few consumers have participated. In many states, regulation of this product has fallen between the cracks of different regulatory agencies (is it insurance or managed care?), leaving consumers without the protections they need. Congress should not expand the program and make it permanent, but should take steps now to fix what is broken (the pricing structure, the need for open enrollment) and await further study results before locking the program into place. With respect to Medicare Select, we urge you to proceed with caution.

Thank you for considering our views.

FOOTNOTES

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers' Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] ''Filling the Gaps in Medicare,'' Consumer Reports, August 1994, p. 526.

[3] It is premature to evaluate the impact of the combination of Medicare select and community rating, since two states (Massachusetts and Washington) are new to Medicare select and since community rating requirements are fairly recent.

[4] ''Evaluation of the Medicare SELECT Amendments—Case Study Report, RTI Project No. 32U–5531, prepared for Office of Demonstrations and Evaluations, Health Care Financing Administration, U.S. Department of Health and Human Services, February 10, 1994, RTI, p. XX–3.

[5] RTI, p. xi.

[6] Three other plans: Foundation Health Plans; National Med; and Omni Health Plan have been approved but had minimal enrollment, that totals less than 500. [RTI, p. IV–17]

[7] p. ix.

[8] RTI, p. xiii.

[9] RTI, p. III–6.

[10] E.g., Oregon and Michigan. RTI, p. XV–1.

[11] E.g., Illinois. RTI, p. XV–3.

[12] RTI, p. ix.

[13] RTI, p. ix.

[14] See, for example, RTI, p. IV–9, IV–10.

[15] In Florida, Select insurers are required to offer at least a basic Plan A in a non-Select form, providing partial protection for people who wish to switch out of Select plans. One side-effect: this provision makes it infeasible for HMO's to offer SELECT plans.

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

Mr. Speaker, this has been an interesting debate. It has been about a lot of things, it has been about almost everything except the underlying legislation. We have talked about the budget, we have talked about Medicare in general we have been told ''why the rush?'' The gentleman who poses the question knows full well why we are acting today. This is a demonstration project that expires today, if we do not act. That is why we are here. That is why I urge it to be passed. I am sure that it will be.

We have also heard about the fact that it might cost more. That is interesting, Mr. Speaker, because when this bill was first passed several years ago, a study was supposed to be done. It was supposed to be available in January, but of course the administration advised us that it would not be ready and it would not be ready for months, so they could not provide it to the authorizing committees as the legislation was being crafted.

However, just a few weeks ago, Mr. Speaker, mysteriously, part of the information, not the full report, was leaked, not to the committees of jurisdiction, but to a Member of the other body who is opposed to the legislation. I find that rather curious. Needless to say, this is not the usual method the administration uses to provide committees of jurisdiction with important information.

Mr. Speaker, time is wasting. We need to get on with this program. Let

me finally end this by saying, No. 1, the study that is required before this program expires in 3 years requires the Secretary to discontinue the program if it is found that Medicare select: has not resulted in savings of premium costs to beneficiaries compared to non-select MediGap policies;

Second, they cannot extend it if it shows that it has resulted in significant additional expenditures for the program; or

Third, it cannot be extended if it results in the diminished access in quality of care. There are plenty of safeguards to ensure that beneficiaries are well protected. I urge my colleagues to join me in supporting the conference report.

Mrs. COLLINS of Illinois. Mr. Speaker, I rise in opposition to the conference report on H.R. 483, the Expanded Use of Medicare Select Policies Act. While I recognize the role that the Medicare select demonstration program that currently exists in my State of Illinois and 14 other States plays, I am concerned that this legislation is being used as a cover for the draconian $270 billion in Medicare cuts included in the budget resolution conference report that passed this body yesterday.

Under the Medicare Select Program, senior citizens on Medicare are allowed to buy private MediGap insurance policies through managed-care providers to supplement what Medicare does not cover. An important objective, but following what happened here yesterday with the GOP budget plan, Medicare select could easily become the only health care option for seniors, as Medicare is gutted, services are curtailed, and older folks have to pick up the pieces through private plans. The end result will be less access to services and higher out-of-pocket costs.

It is crystal clear to anyone watching the actions of the majority party in the 104th Congress that devastating changes to Medicare are ahead. There is rampant GOP discussions ongoing about turning Medicare into block grants for the States and based on what happened in the House welfare reform legislation to the Federal School Lunch and Breakfast Programs, I know that ''block grant'' is a code word for cutting, slashing, and eliminating.

Let's not fool anyone Mr. Speaker, H.R. 483 is one of the first threads with which to unravel the entire Medicare system. I have far too many senior citizens in my district who depend on Medicare and would be crippled by Republican cuts to the program to allow it to be treated as it has by the Speaker and his cronies.

I urge my colleagues to vote ''no'' on this conference report and reject the Republicans' attempts to balance the budget on the backs of seniors and then hand them the check when the bill comes due.

Mr. Speaker, I yield back the balance of my time and I move the previous question.

The SPEAKER pro tempore. Pursuant to House Resolution 180, the previous question is ordered.

The question is on the conference report.

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

The SPEAKER pro tempore. Under the rule, the yeas and nays are ordered.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 350, nays 68, not voting 16, as follows:

[Roll No. 467]

YEAS—350

Ackerman	Edwards	Kolbe
Allard	Ehlers	LaHood
Andrews	Ehrlich	Lantos
Archer	Emerson	Largent
Armey	Engel	Latham
Bachus	English	LaTourette
Baesler	Ensign	Laughlin
Baker (CA)	Eshoo	Lazio
Baker (LA)	Everett	Leach
Baldacci	Ewing	Levin
Ballenger	Farr	Lewis (CA)
Barcia	Fawell	Lewis (KY)
Barr	Fazio	Lightfoot
Barrett (NE)	Flake	Lincoln
Barrett (WI)	Flanagan	Linder
Bartlett	Foley	Lipinski
Barton	Forbes	Livingston
Bass	Fowler	LoBiondo
Bateman	Fox	Lofgren
Becerra	Franks (CT)	Longley
Beilenson	Franks (NJ)	Lowey
Bentsen	Frelinghuysen	Lucas
Bereuter	Frisa	Luther
Berman	Frost	Maloney
Bevill	Funderburk	Manzullo
Bilbray	Furse	Martini
Bilirakis	Ganske	Mascara
Bishop	Gejdenson	Matsui
Bliley	Gekas	McCarthy
Blute	Gephardt	McCollum
Boehlert	Geren	McCrery
Bonilla	Gilchrest	McDade
Bono	Gillmor	McHale
Brewster	Gilman	McHugh
Browder	Goodlatte	McInnis
Brown (CA)	Goodling	McIntosh
Brown (OH)	Gordon	McKeon
Brownback	Goss	McNulty
Bryant (TN)	Graham	Meehan
Bunn	Green	Menendez
Bunning	Greenwood	Metcalf
Burr	Gunderson	Meyers
Burton	Gutierrez	Mfume
Buyer	Gutknecht	Mica
Callahan	Hall (OH)	Miller (FL)
Calvert	Hall (TX)	Mineta
Camp	Hamilton	Minge
Canady	Hancock	Molinari
Cardin	Hansen	Mollohan
Castle	Harman	Montgomery
Chabot	Hastert	Moorhead
Chambliss	Hastings (WA)	Moran
Chapman	Hayes	Morella
Chenoweth	Hayworth	Myers
Christensen	Hefley	Myrick
Chrysler	Hefner	Neal
Clayton	Heineman	Nethercutt
Clinger	Herger	Neumann
Coble	Hilleary	Ney
Collins (GA)	Hobson	Nussle
Combest	Hoekstra	Oberstar
Condit	Hoke	Obey
Cooley	Holden	Ortiz
Costello	Horn	Orton
Cox	Hostettler	Oxley
Cramer	Houghton	Packard
Crane	Hoyer	Pallone
Crapo	Hunter	Parker
Cremeans	Hutchinson	Pastor
Cubin	Hyde	Paxon
Cunningham	Inglis	Payne (VA)
Danner	Istook	Peterson (FL)
Davis	Jackson-Lee	Peterson (MN)
de la Garza	Jacobs	Petri
Deal	Johnson (CT)	Pickett
DeLauro	Johnson (SD)	Pombo
DeLay	Johnson, E. B.	Pomeroy
Deutsch	Johnson, Sam	Porter
Diaz-Balart	Johnston	Portman
Dickey	Jones	Poshard
Dicks	Kaptur	Pryce
Dixon	Kasich	Quillen
Doggett	Kelly	Quinn
Dooley	Kennedy (MA)	Radanovich
Doolittle	Kennelly	Rahall
Dornan	Kim	Ramstad
Doyle	King	Reed
Dreier	Kingston	Regula
Duncan	Kleczka	Richardson
Dunn	Klug	Riggs
Durbin	Knollenberg	Rivers
Roberts	Shuster	Tiahrt
Roemer	Sisisky	Torkildsen
Rogers	Skeen	Traficant
Rohrabacher	Skelton	Upton
Ros-Lehtinen	Smith (MI)	Vento
Rose	Smith (NJ)	Volkmer
Roth	Smith (TX)	Vucanovich
Roukema	Smith (WA)	Waldholtz
Roybal-Allard	Solomon	Walker
Royce	Souder	Wamp
Sabo	Spence	Ward
Salmon	Spratt	Weldon (FL)
Sanford	Stearns	Weldon (PA)
Sawyer	Stockman	Weller
Saxton	Stump	White
Scarborough	Talent	Whitfield
Schaefer	Tanner	Wicker
Schiff	Tate	Wilson
Schumer	Tauzin	Wise
Scott	Taylor (MS)	Wolf
Seastrand	Taylor (NC)	Woolsey
Sensenbrenner	Tejeda	Wynn
Serrano	Thomas	Young (FL)
Shadegg	Thornberry	Zeliff
Shaw	Thornton	Zimmer
Shays	Thurman	

NAYS—68

Abercrombie	Hilliard	Rush
Bonior	Hinchey	Sanders
Borski	Jefferson	Schroeder
Brown (FL)	Kanjorski	Skaggs
Clay	Kennedy (RI)	Slaughter
Clyburn	Kildee	Stark
Coleman	Klink	Stokes
Collins (IL)	LaFalce	Studds
Collins (MI)	Lewis (GA)	Stupak
Conyers	Manton	Thompson
Coyne	Markey	Torres
DeFazio	Martinez	Torricelli
Dingell	McDermott	Towns
Evans	Meek	Tucker
Fattah	Miller (CA)	Velazquez
Fields (LA)	Mink	Visclosky
Filner	Murtha	Waters
Foglietta	Nadler	Watt (NC)
Ford	Olver	Waxman
Frank (MA)	Owens	Williams
Gibbons	Payne (NJ)	Wyden
Gonzalez	Pelosi	Yates
Hastings (FL)	Rangel	

NOT VOTING—16

Boehner	Fields (TX)	Stenholm
Boucher	Gallegly	Walsh
Bryant (TX)	McKinney	Watts (OK)
Clement	Moakley	Young (AK)
Coburn	Norwood	
Dellums	Reynolds	

□ 1303

The Clerk announced the following pair:

On this vote:

Mr. Watts of Oklahoma for, with Mr. Dellums against.

Mr. MARTINEZ changed his vote from ''yea'' to ''nay.''

Mr. KING, Mr. BERMAN, Ms. RIVERS, and Mrs. MALONEY changed their vote from ''nay'' to ''yea.''

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 1289

Ms. ESHOO. Mr. Speaker, I ask unanimous consent that my name be removed as a cosponsor of H.R. 1289.

The SPEAKER pro tempore (Mr. EWING). Is there objection to the request of the gentlewoman from California?

There was no objection.