Two young people become infected with HIV in this country every hour, and there are 11 new infections worldwide every minute. The figures that the gentleman from Illinois (Mr. DAVIS) used were that around 450,000 people have died in the U.S. of AIDS, 22 million worldwide. We must do more to protect this new generation from suffering. That is all too familiar to previous generations.

Mr. Speaker, I call on my colleagues to work with us to increase the funding, to improve the quality of life, to end the scourge of AIDS.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, once again this evening, as we are back from the Memorial Day break, I would like to take up the issue of health care. As my colleagues know, I have been down here with many of my Democratic colleagues many times over the last few months since the session began and since this new administration began in January, basically speaking out on three major health care issues that have not been addressed, in my opinion, by the President and the Republican leadership in the Congress, and that is the need to reform HMOs and the need to pass a Patients' Bill of Rights that would reform HMOs.

There are so many problems that people now have with their HMO or their managed care organization in not having proper access to care, not being able to go to the hospital of their choice, not being able to, if they have a grievance, have an independent review of the decision by the HMO to deny them care; and I will get into this more this evening.

The second issue is the need for a Medicare prescription drug benefit. When I go home, and I was home for the last 10 days in New Jersey, my seniors and my constituents complained more about the high cost of drugs and how they cannot pay for prescription drugs and that it should be included in Medicare. I agree, and that needs to be addressed.

The third issue is access for the uninsured. More Americans every day have no health insurance. Most of those are working people, and we need to find ways to address those concerns and have them insured and covered for their health care.

My point tonight, and I would like to yield now to some of my colleagues, but my point tonight is that we really face, I hope, a different situation tomorrow here in the Congress, here in Washington, because of the change in the other body, in the Senate. I have watched over the last 4 or 5 months, and during the course of the campaign, President Bush mentioned many times that he was going to pass a Patients' Bill of Rights and reform HMOs, that he was going to have a prescription drug benefit, that he was going to address the problem of people who do not have health insurance. Yet over the last 4 or 5 months of this administration, these issues have not come to the floor, they have not been moved in committee in either House. The Republican leadership, in conjunction with the Republican President, have simply dropped the ball on these issues.

I was heartened to find that during the break with the changeover in the Senate to Democratic control tomorrow, that the leaders in that body, the Democratic leaders in that body have said that the first order of business when they come back next week most likely, next week is going to be to move the Patients' Bill of Rights in the other body, and that that will be followed soon with these other health care issues.

So finally now we may have an opportunity to get legislation passed, at least in the other body, on some of these issues by the Democrats that will come over here and force the hand, I hope, of the Republican leadership here and the Republican President.

With that, Mr. Speaker, I would like to yield to the gentleman from Rhode Island (Mr. LANGEVIN).

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Mr. LANGEVIN. Mr. Speaker, I am pleased to rise and join my colleague, the gentleman from New Jersey (Mr. PALLONE) on this important topic.

Mr. Speaker, I rise to address in particular the skyrocketing price of prescription drugs, which is making this essential component of our Nation's health care system inaccessible to those who need it most.

Older Americans, who make up 13 percent of the U.S. population, account for 34 percent of all prescriptions dispensed and 42 cents of every dollar spent on prescription drugs. The average Medicare beneficiary fills 18 different prescriptions per year.

Obtaining prescription drugs is a clear necessity for our senior citizens. Yet, the annual spending per capita in the Medicare population for prescription drugs has jumped from $674 in 1996 to $1,539 in the year 2000, and is expected to climb to over $3,700 in 2010.

Overall, prescription drug prices rose 306 percent between 1981 and 1999, while the Consumer Price Index rose just 99 percent during that same period. In the year 2000, total spending in the U.S. for prescription drugs was $116 billion, more than twice the $51 billion spent in 1993. That amount is expected to triple to $366 billion by 2010. These escalating prices can and must cease.

For every dollar that a consumer pays for a prescription drug at the pharmacy, 74 cents goes to the drug manufacturer, 3 cents goes to the wholesale distributor, and 23 cents goes to the pharmacy. In 2000, pharmaceutical companies had after-tax median profits of 19 percent, compared with 5 percent for all other Fortune 500 companies combined.

While I recognize the importance of researching and developing technological advancements that have helped numerous Americans, and of course we all want to see this continue, I know drug manufacturers do not need such astronomical profits to ensure continued research.

Mr. Speaker, let us face facts: most core research for prescription drugs is funded through NIH. In addition, pharmaceutical companies dedicate more than 18 percent of revenues to profits and 30 percent to marketing and administration, compared with just 12 percent to research and development. In fact, the 12 drug companies with the highest revenues spent three times as much on marketing as on R&D in 2000.

Mr. Speaker, access to prescription drugs is critical to the survival and maintenance of an accessible quality of life for millions of our senior citizens. As we know, Medicare does not offer any prescription drug program, and most seniors have found that the Medicare+Choice program has not provided the kind of opportunities Congress thought it would.

As a result, today at least one in three people in the Medicare population have no drug coverage at all in the course of a year, and nearly half have no coverage for at least part of an entire year. These Medicare beneficiaries spend on average 83 percent more for their medications than those with drug coverage. Moreover, almost half of Medicare beneficiaries without any form of prescription drug coverage have incomes less than 175 percent of the poverty level. That means they had incomes of $15,000 in 2001.

That, Mr. Speaker, is why we need to require drug companies to give local pharmacies the best price they give their most favored customers, or the average foreign price, and reinstate the requirement for reasonable pricing on products that were researched and developed using taxpayer money via NIH.

Moreover, we need to authorize the Federal government to buy drugs in bulk and at a discount for Medicare beneficiaries.

And most of all, we must provide a Medicare prescription drug plan. While the administration's budget includes $153 billion over 10 years to provide for prescription drug coverage and Medicare reforms, this plan falls far short of a comprehensive drug coverage program.

The 4-year Immediate Helping Hand proposal provides block grants to the States to help low-income seniors purchase prescription drugs, and then an unspecified Medicare prescription drug

benefit is to be developed, along with Medicare restructuring.

According to the administration's own cost estimates, adjusted by CBO's projections of drug inflation, covering only the low-income population's prescription drugs would cost over $200 billion, almost $50 billion more than what has been provided in the budget.

Furthermore, the Immediate Helping Hand program would deny eligibility to about 20 million Medicare beneficiaries, most of whom lack affordable, dependable prescription drug coverage.

For instance, under the administration's plan, an 85-year-old widow with an annual income of $17,000 would receive no assistance with her prescription drug costs. Now that we have passed what I believe is an irresponsible and partisan budget, providing the kind of comprehensive and effective drug benefit our seniors need appears to be next to impossible.

Mr. Speaker, I urge my colleagues not to forget our seniors, and to not neglect the American public, who is counting on us to follow through on a promise that was made by Democrats and Republicans alike to provide a quality prescription drug plan for Medicare beneficiaries.

Mr. PALLONE. Mr. Speaker, I want to thank my colleague, the gentleman from Rhode Island, for his statement.

If I could just mention two things that he brought up, which I think are so crucial, the whole issue is affordability. Prescription drug affordability is really of the utmost importance to seniors and to people with disabilities.

This is what I have heard back at home the last 10 days, the last week or so, that seniors that have major financial problems with purchasing their necessary medications, they have to choose between paying the rent or buying food, and it is basically because of growing out-of-pocket expenses. Even people that have some sort of limited coverage because they are in an HMO or because of some kind of benefit they received on the job that they get in their retirement are finding that the out-of-pocket costs just continue to rise exponentially every year.

We have done a number of studies with the Committee on Government Reform with the gentleman from California (Mr. WAXMAN) in various States, in various congressional districts, that have shown that drug manufacturers engage in widespread price discrimination, so that seniors are paying significantly more for their drugs than they would if they were in another country.

I want to thank our colleague, the gentleman from Rhode Island (Mr. LANGEVIN), for what he brought up. I think it is so important.

I know our colleague, the gentleman from Maine (Mr. ALLEN), has a bill called the Prescription Drug Fairness Act or Fairness for Seniors Act that would link the price to the average farm prices in certain countries. Maybe he might discuss that.

I yield to the gentleman from Maine (Mr. ALLEN) to have him talk about that. I know he has other health care issues to bring up as well.

Mr. ALLEN. Mr. Speaker, I thank the gentleman from New Jersey (Mr. PALLONE) for yielding to me, and I thank particularly our friend, the gentleman from Rhode Island (Mr. LANGEVIN), for coming here tonight and speaking on this particular topic.

We really have built strong support on the Democratic side of the aisle for the discount, which would be about 35 percent for all Medicare beneficiaries in the cost of their prescription drugs reflected in the bill that I have sponsored, the Prescription Drug Fairness for Seniors Act. Also, we know that seniors ultimately need a Medicare prescription drug benefit, not a private insurance company prescription drug benefit. That is really the choice that is presented between the Democratic side of the aisle and the Republican side of the aisle.

If I could say a couple of things, I guess I want to go beyond the prescription drug issue for a moment and talk about Medicare generally. The American public has every reason to feel a bit confused because in the last election there was all this talk about prescription drug coverage for seniors, and there has been talk for years about Medicare reform. The question always is, what is contained in those little words ''Medicare reform.''

Well, today there is breaking news, Mr. Speaker, on health care, breaking news on Medicare. I guarantee the Members, it will not be on the evening news, it will not be covered on the front page of any newspaper tomorrow, but still, it is breaking news.

It comes in a story by Robert Pear in the New York Times this morning. The headline is significant: ''Medicare Shift Toward HMOs Is Planned.'' So the question is, planned by whom? Well, planned by the Bush administration. Now at last we can see a little more clearly what this administration is up to when it comes to Medicare.

There are many people on the Republican side of the aisle who have never liked Medicare because, after all, it is a government health care program. It takes care of our seniors. It has been there since 1965. It was put in place because in 1965 only one-half of all of our seniors had any health insurance at all. Medicare stepped in where the private insurance industry simply would not provide coverage to our seniors. It has been a success. It is there in every State. It is equal. It is trusted by our seniors. It is respected by our seniors.

Well, the President has appointed and the Senate has confirmed a new administrator of the Health Care Financing Administration, the organization that runs Medicare. His name is Thomas Scully, and he made his first speech, significantly, at the United States Chamber of Commerce.

Here is what he said: ''The government is better in the long run when it is a buyer of insurance, rather than an insurer.'' What did Mr. Scully mean by that? He meant that it would be better for our seniors to have private insurance than it would be to be under Medicare, under a Federal health care plan.

Let us look at some of the facts. I am interested in this because the program that allows some, about 14 or 15 percent, of our seniors to get their Medicare benefits through a private insurance company has a name. It is called Medicare+Choice. What that Medicare+Choice refers to is coverage that will be obtained through HMOs.

Now, this is wonderful, I suppose, in a few places in this country, particularly in our big cities, because there we may have several competing plans that are there to try to provide more choices to seniors, and in some big cities in this country it works, with an exception which I will note later.

But in my home State of Maine, we do not have a single, not one, HMO providing insurance for our seniors. We did last year. We had one company which had about 1,700 beneficiaries. Two of them were my parents. But the insurance company decided it could not make money in Maine, and so it pulled out. My parents had to go looking for another supplementary health care insurance, causing all sorts of confusion and upset.

□ 1930

Well, what is happening across the country? Medicare, I would note, Medicare does not pull out of a State when it is not making money, but private insurance companies do.

In fact, in the last 3 years, managed care plans have dropped more than 1.6 million Medicare beneficiaries; 1.6 million beneficiaries dropped. Why? Because the company could not make money off them, could not make money in a particular area, could not make money off some of our seniors who are sicker and need more help than others.

Now, until Mr. Scully was chosen and confirmed as the administrator of the Health Care Financing Administration, Medicare officials have historically professed to be neutral. They have said we are not taking sides between traditional Medicare fee-for-service, which is there for about 75 percent of all Medicare beneficiaries, and the 15 percent who get their coverage through an HMO. They are trying to, over the last few years, the goal has been, under the Clinton-Gore administration, to make sure that there was a level playing field.

But as I said, that has all changed. That has changed because Mr. Scully has made it perfectly clear that the government is better in the long run when it is a buyer of insurance rather than an insurer. In other words, traditional Medicare that Americans have come to rely on and respect and depend on because they know the benefits will not change every year, they know Medicare will not pack up and leave a

State when it is not making money, that system is now under attack from the administration.

Because what Mr. Scully wants to do is he wants up to 30 percent of elderly patients in managed care by 2005. That means we have to reverse this trend of managed care companies simply dropping people. But it is far more significant than that.

Mr. Scully, I suggest, has not done his homework. Why do I say that? Because he does not yet understand that these managed care plans cost more than traditional fee-for-service Medicare. As Dave Berry says, I am not making this up, it is right here. In a GAO report published in August of 2000, this is a review of Medicare+Choice plans. This is a review of how managed care is working in Medicare. Here is the title, ''Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending.'' Adding billions to spending.

What the GAO did was to do a comparison between traditional old fee-for-service Medicare and these new health maintenance organization managed care plans for our seniors. They make the point, the GAO makes the point that Medicare+Choice was designed to expand beneficiaries' health plan options, and it was supposed to improve Medicare's financial posture by better controlling spending growth.

Well, lately, the industry has been saying over and over again the payments that we get that the health insurance industry gets under Medicare+Choice plans are too low. We cannot make money. That is why we are dropping people in Maine and all across the country.

Well, the GAO looked at 210 of the 346 Medicare+Choice plans that were in operation in 1998. These plans enrolled 87 percent of all beneficiaries in Medicare+Choice plans. What did they find? I quote, ''Medicare+Choice, like its predecessor managed care program, has not been successful in achieving Medicare savings. Medicare+Choice plans attracted a disproportionate selection of healthier and less-expensive beneficiaries relative to traditional'' fee-for-service Medicare, ''while payment rates largely continued to reflect the . . . costs of beneficiaries in average health.''

Here is the key, this is a quote right out of the GAO: ''Instead of paying less for health plan enrollees, we estimate that aggregate payments to Medicare+Choice plans in 1998 were about $5.2 billion . . . or approximately $1,000 per enrollee, more than if the plans' enrollees had received care in the traditional'' fee-for-service program. ''It is largely these excess payments, and not managed care efficiencies, that enable plans to attract beneficiaries by offering a benefit package that is more comprehensive than the one available to FFS,'' fee-for-service, ''beneficiaries, while charging modest or no premiums.''

What does that mean? It means that traditional fee-for-service Medicare is cheaper, $5.2 billion in 1998 alone for 15 percent of the elderly population. Fee-for-service is cheaper than Medicare managed care. So those managed care beneficiaries in this country who are getting prescription drug benefits are getting it, not because the managed care company is saving money, they are getting it because the managed care company is getting more money over and above what it would get for traditional fee-for-service beneficiaries. It is out of that money that the additional benefits are coming.

We are making a huge mistake in this country because we have devised a system through Medicare+Choice which is going to drag the insurance industry into Medicare, will provide our seniors with less effective and fair and beneficial services at a higher cost to the taxpayer.

Now we have the Bush administration stepping up and saying, what we really need in this country is more health insurance companies taking over Medicare. Mr. Scully is wrong. Fee-for-service Medicare, traditional Medicare works. What our seniors need is a system that is reliable and predictable and stable, something they can count on. They do not need insurance companies changing the benefits, reducing benefits one year, raising premiums the same year, pulling out of a State because they are not making enough money.

Medicare needs reform, but it does not need to be taken over by HMOs. That is what, in his first major speech, Mr. Scully of the Health Care Financing Administration is saying is his goal for Medicare, to turn it over, to turn more and more of it over to our insurance companies. If he succeeds in doing that, our seniors will be worse off than they are today. Our taxpayers will be worse off than they are today. But the health insurance industry will be making more money and their stocks will be higher than they are today. That is what this is all about.

At the end of the day, what Mr. Scully is suggesting is not the best system for our seniors, it is not the best system for consumers, it is the best system for the health insurance industry. That is what it is about. Those who gave money in the past election campaign will get their reward if this administration can succeed in undermining, changing our Medicare system that seniors have grown to depend on, and turning it over to private industry to make more money, more profits than ever before. It is abomination.

This Congress, if we do nothing else, has got to stop this administration from taking Medicare apart and turning it over to the private sector.

I have gone on some period of time. This is an issue I care deeply about. I certainly want to thank the gentleman from New Jersey (Mr. PALLONE) for holding this event this evening and allowing all of us to come forward and express our views.

Mr. PALLONE. Mr. Speaker, I want to thank the gentleman from Maine (Mr. ALLEN) for what he said this evening. I think it is so important. I am amazed because I watched the Republican leadership and the Republican President, and it just seems sometimes I think that they are motivated, as the gentleman said, just because of special interests. In other words, the health insurance companies give a lot of money to their campaigns, so they want to support them.

Other times, I think they are just stuck in this sort of right-wing antigovernment idealogical cloud of some sort, that they are just not thinking about what is practical. They just think anything that the government does has to be bad because idealogically they do not believe in the government.

So when we have a good program like Medicare, traditional Medicare fee-for-service that works as effective and is actually saving money is a bargain, they do not want to use it, they want to tear it down. Whether it is their ideology, which I think is very backward, or it is the special interest money they are getting from the insurance company, the bottom line is they are just not being practical.

If my colleagues remember last session in the previous Congress, the House Republican leadership tried to establish what they call a prescription drug-only insurance policy. In other words, rather than expanding Medicare and have a guaranteed benefit under Medicare for prescription drugs, they wanted to give people money so they can go out and buy a prescription drug-only policy which, again, harkens back to this ideology that government and Medicare cannot do the job.

The insurance companies came before the various committees of jurisdiction and said, well, we do not want you to do that. We are not going to sell you that insurance. We had an example in the State of Nevada which basically did that, Republican-controlled legislature, that passed a bill and said, we will give you money, you go out and buy these drug-only policies, and nobody would sell them. So for the life of me, I cannot understand what they are up to.

The same thing, as the gentleman from Maine said, with the HMOs. The HMOs we know are getting out of the Medicare business. They are either dropping seniors, or they are increasing out-of-pocket cost for prescription drugs so that the prescription drugs are unaffordable even for seniors that have the HMO.

Why in the world would we want to go out and encourage HMOs as the way to address the need for prescription drug benefit? Why in the world would we want to suggest these insurance policies that only cover prescription drugs? I have not heard much about that in this Congress. I guess maybe they dropped that; although I am sure there are some out there that still want to do that.

I mean, what the Democrats have been saying is that we want Medicare

to be expanded to include prescription drugs as a guaranteed benefit, universal benefit. When I go and talk to my seniors in New Jersey, they are not interested in this low-income benefit because most low-income seniors get some kind of drug benefit if they are covered by Medicaid. And in a lot of States now, not all, but many States have expanded coverage to cover the low income even a little bit above Medicaid, as is the case in New Jersey.

The problem, though, is for the middle class, the middle-class senior who does not get Medicaid, is not covered by their State program because their income is a little too high or they do not have a State program, and at the same time cannot get a decent HMO policy that is going to cover their prescription drugs.

So when the President says that he wants to do this low-income benefit, I think he calls it the helping hand, immediate helping hand, and it establishes block grants for States to provide for prescription coverage for some low-income seniors and some seniors with catastrophic drug costs, he would limit full prescription drug coverage to Medicare beneficiaries with incomes up to 35 percent above the poverty level, which is $11,600 for individuals, $15,700 for couples, and seniors with out-of-pocket prescription spending of over $6,000 per year.

Again, this is not the problem. The middle-income senior falls above that $11,000 for individual, $15,000 for couples in most cases, and they do not have the out-of-pocket catastrophic expenses of over $6,000 per year. Most seniors are not going to benefit from this, even if it got passed.

I do not even see any movement on the part of the Republican leadership in either House or the President to move this anyway, so I do not even know why I am talking about it, because he talks about it during the campaign, but I do not even see an effort to move that.

Hopefully with the Democrats now in the majority starting tomorrow in the other body, in the Senate, we will now see a decent prescription drug benefit move, get passed in the other body, and come over here where we can try to persuade the House Republican leadership to take it up.

Let me just, Mr. Speaker, if I could give a little indication of what the Democrats here in the House and in the other body would like to see as a prescription drug benefit. We have certain principles that we have been espousing.

First of all, this prescription drug benefit must be part of Medicare. Medicare works. It is cost effective. Let us include a guaranteed benefit for those who want it under Medicare.

Secondly, it should be voluntary, just like one opts and pays a premium so much per month for one's doctor bills, for one's coverage of one's doctor bills, expenses. We would have this be a voluntary program where one pays a certain premium and one gets one's prescription drugs.

Thirdly, the Democrats have been saying that the prescription drug benefit for seniors has to be affordable. Obviously, the premium has to be fairly low per month. One cannot be expected to pay a significant amount of money out of pocket when one goes and gets each individual prescription.

It goes back to what my colleague from Rhode Island was saying about affordability for seniors. I also think it is important that this benefit be defined. In other words, Medicare beneficiaries, regardless of where they live, should be guaranteeing access to a defined drug benefit at the same standard premium.

□ 1945

You know, people have to know that the prescription drugs they need are included in the program. This is what the Democrats have been talking about.

And we also want to build into our proposal an end to price discrimination. We talked a little before about the bill of my colleague, the gentleman from Maine (Mr. ALLEN); about how he wants to link the price more towards that charged in other countries that are developed countries like the United States. There are ways of dealing with the price discrimination issue, and that is certainly one of them.

Another is to basically have the government, through benefit providers in each region, purchase and negotiate prices for the drugs so that we are getting volume discounts. That is certainly another way to try to deal with the price issue. This has got to be done.

I was home again last week, for the last 10 days, and this is what our seniors are talking about. We need to take it up. Hopefully, now that the Democrats are in the majority in the other body, they will send a bill over here; and we will be able to pressure the Republican leadership here in the House to take up a prescription drug bill that helps all Medicare recipients.

Now, I wanted to talk, if I could, Mr. Speaker, before I conclude this special order this evening, about two other health care issues which I mentioned at the beginning of this special order, and one of them, because of what is happening in the Senate, in the other body, is likely to move even quicker than a prescription drug benefit. And that is fine, I would like to see these important health care issues and this legislation get over to the House as soon as possible, and that is the Patients' Bill of Rights, or HMO reform.

Again, when I talk to my constituents, regardless of age, about HMOs, because many people in New Jersey are in HMOs and they have become very concerned because many times they are denied the care that they think they need. Either they cannot go to a particular hospital in an emergency, they cannot get access to a specialist, or they are denied a particular operation or procedure because the insurance company, the HMO, says that it is too innovative. What they really mean is it is too expensive and they do not want to pay for it.

The two issues that I think are so important with HMO reform, and which are addressed in the Patients' Bill of Rights in sort of a general way, is the definition of what is medically necessary; who is going to define whether an operation, a procedure, a hospital, a stay in a hospital is necessary; is it going to be the insurance company, which wants to save money; or is it going to be the patient and the physician. Because, after all, you and your physician care about your health.

Basically, what the Patients' Bill of Rights does is to say that in general that decision is made by the physician, the health care professional, and the patient, not by the insurance company. They are the ones that that decide what is medically necessary.

The second is if someone has been denied care, the HMO says they cannot have a particular procedure, they have to leave the hospital, what then does that individual do; how do they redress their grievances; where do they go. Now, unfortunately, in many cases, they can only go to the HMO, who have said, no, we made that decision and too bad. We want a procedure which allows an individual to go to an independent board outside the HMO that has the power to overturn that decision or we want to be able to go to court as a last resort.

Now, let me just talk about some of the little more specific although still general points about the Patients' Bill of Rights and the real Patients' Bill of Rights. And I do not want to put him on the spot, but I see one of my heroes over here on this issue, the gentleman from Iowa (Mr. GANSKE), and he along with the gentleman from Michigan (Mr. DINGELL), a Democrat, and this is really a bipartisan effort because there are some Republicans that support this bill, a lot of them frankly, but, unfortunately, not the leadership in the Republican Party, have put together a bill called the Dingell-Ganske bill, or the Ganske-Dingell bill, which is the real Patients' Bill of Rights that I would like to see and that most if not all Democrats would like to see passed.

Just to give you an idea of some of the principles that are in here, first of all it has to protect all patients with private insurance, not just some. Some of the Republican bills only protect certain types of people. All patients with private insurance. There has to be the ability to hold the plans accountable, which I discussed. There has to be a fair definition of medical necessity, which means that it has to be up to the physician and the patient to determine that.

There has to be guaranteed access to specialists, access to out-of-network providers. If there is not someone available who can handle a patient's situation, they can go out of the network.

There also has to be a prohibition on improper financial incentives. The HMO cannot encourage the doctor to deny care or not provide certain care

and get some sort of financial incentive to do so. There has to be access to clinical trials. There has to be a prohibition on gag rules. In other words, some of the HMOs say that the doctor cannot tell a patient if they need a particular treatment in his or her opinion because it is not covered. So if it is not covered and he or she thinks a patient needs it, they are not allowed to tell because the insurance company will not pay for it. That is ridiculous.

Emergency room access if it is needed. If something happens, an individual has a heart attack, they have an accident, that that person can go to the nearest emergency room rather than go to one 50 miles away and die or become seriously injured on the way. And the list goes on.

What I am fearful of, and I guess I am a little less fearful now that the Democrats are in the majority in the other body, is that even though President Bush said he would support a Patients' Bill of Rights and said in fact that he would support a Patients' Bill of Rights very similar to what they have in the State of Texas, he has essentially said that he opposes the Dingell-Ganske bill, which in the other body, the Senate, is sponsored again on a bipartisan basis by Senator MCCAIN and Senator KENNEDY. The President has been variously quoted over the past few months saying this bill that so many of us support in the House and in the other body is too costly and that he would veto it.

He said his primary objection to these bills currently in the Congress is that they do not contain reasonable caps on damage awards against health insurance organizations or insurance. He wants to have caps, and not very high caps in terms of the amount of money that a person can recover if they go to court. And then he has other concerns; that he does not like the particular court that should be allowed to sue under the Dingell-Ganske bill.

The point of the matter is, Mr. Speaker, that the President and the Republican leadership in both bodies have been fiddling with this issue for the past 4 or 5 months. They say they are for a patients' bill of rights, but they do not articulate exactly what they want. All they do essentially is say they do not like the bill that most of us support, the Dingell-Ganske bill. I am hopeful now that the other body becomes Democratically controlled tomorrow, that as the new majority leader, Mr. DASCHLE, said, this is going to be on the agenda probably next week.

Now, if and when it passes over in the other body and it comes over here, that will allow us to pressure—

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. ISSA). It is not in order in a debate to specifically urge the Senate to take certain actions, and the gentleman will be aware of that.

Mr. PALLONE. Mr. Speaker, I was not aware, and I will not cite that again.

The point I am trying to make, though, is that we really need a good Patients' Bill of Rights. I suspect I am going to be hearing more about it later this evening from my colleague, the gentleman from Iowa (Mr. GANSKE), and I think I will stop with that particular issue for now.

I did want to spend a little time tonight, though, talking about the problem of the uninsured, the number of people who are uninsured. That number continues to grow and needs to be addressed as well here in the Congress.

Mr. Speaker, I see one of my colleagues, who has been very active on the health care issue, and who is a member of our health care task force on the Democratic side, is here; and I would like to yield to him at this point.

Mr. RODRIGUEZ. First of all, Mr. Speaker, once again let me thank the gentleman for his efforts in the area of health care. As the gentleman mentioned, the problem that we encounter now is with the uninsured, and that number continues to grow. We have over 44 million uninsured.

I think that one of the dilemmas we face as we look throughout this country, there are hardworking people that are not poor enough to qualify for Medicaid, not old enough to qualify for Medicare, and yet find themselves working for small companies that do not give them an opportunity to have access to insurance coverage. And I can attest to the gentleman that if someone is not working for government or a major corporation, they do not have any access to health care. So that we have a real dilemma, because we do provide it for the indigent, we do provide it for the elderly to some extent, but when it comes to those working Americans out there trying to make ends meet, we have a difficulty in terms of providing access to health care.

There is a real need for us to come to grips with that issue. We have not done that in the past, unfortunately, and we need to do so. We are hoping that the administration can start moving in this direction as they dialogued about the issue of health care during the campaign. We hope they will come up to meet those promises that they made on health care and the uninsured, not to mention those that are insured but who are what we call the underinsured, the ones that have access to some degree but yet do not have full coverage, such as prescription coverage.

I know that the gentleman has covered the issue of prescription coverage, but I just want to keep mentioning it because we need to keep that issue on the forefront. It is an issue that continues to be one of the key issues in America and it is one of the problems that we were elected to respond to and we have not yet done so. We are hoping that we will begin to cover that.

When we look at prescription coverage under Medicare, there is no doubt that when we devised Medicare, from the very beginning, that at that point they did not see the importance of prescription coverage. We know now that prescription coverage is key for access to good quality care. We know the importance of that, and so we need to look at that issue. And the responses that we have before us from the administration have not been adequate.

There is only one State that has tried it, and it has not been that successful, and that is because our seniors are the ones that utilize prescriptions the most. That is where the private sector will make the less amount of profit in any area, and so it is an area where we all need to participate and make sure that we can help out when it comes to prescription coverage. It does not make any sense for us to make the diagnosis, to find out that they are in need, when we do not provide them the prescriptions that are needed to be able to cover some of those needs.

The other thing that just does not make any sense is that we provide prescription coverage for Medicaid, for the indigent, yet we do not provide it for our seniors. So there is a real need for us to kind of come to grips on that issue of not only prescription coverage but the uninsured. I know there are a couple of proposals out there, and we are hoping that we can begin to go throughout the country to dialogue about the importance of health care in this country. The fact is, we still have a long way to go. We have not come to grips with these issues, and we need to get more pressure on the politicians up here to make some things happen.

The only reason we had the Patients' Bill of Rights the last time, as the gentleman well knows, is because we decided to do a discharge petition that forced the Congress to have to deal with it. Because of that, I think we were able to make that happen, and we did pass a good bill. Unfortunately, it was killed during conference and so that did not materialize. So what is important now is that we have a new session, and we need to move forward in that area.

So I just wanted to take this opportunity now to thank the gentleman for what he has been doing on health care. I will be talking later on on the issue of AIDS, and I look forward to the gentleman's participation in that area.

Mr. PALLONE. Mr. Speaker, I want to thank my colleague from Texas. And I do appreciate the fact that the gentleman is going to spend the hour later this evening talking about AIDS and what we need to do further. There has been a lot of attention paid to the fact, and during the break over the last week I read a number of articles, about the increased incidence of AIDS, particularly amongst African American gay men; that there was just an incredible increase in the incidence of AIDS and HIV. People think that the crisis has subdued somewhat in the United States but it is still out there, and in many communities it is actually getting worse.

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The other thing if I could, I am so glad the gentleman mentioned the uninsured, and I know that the gentleman has mentioned it many times and the need to address that issue.

Once again, I want to point out that even though the President talked about this problem during the campaign, I do not see any effort on the part of President Bush or the Republican leadership to address the issue.

One of the things that the President talked about was this idea of a tax credit. The basic design of the Bush plan was an individual credit of $1,000 for those with an annual income up to $15,000. That phases down to zero at $30,000, and a family credit of $2,000 with income up to $30,000 that phases down to zero. That sounds good in theory to get a $1,000 credit toward health care insurance, but it will not solve the problem of the uninsured.

First, I do not see the President trying to accomplish this. He talked about it during the campaign, but there is nothing happening. We do not see it moving in committee or any effort being made.

Beyond that, it is available only to those not enrolled in employer-sponsored insurance or Medicaid policy and available only to those who purchase nongroup insurance.

Basically we are talking about an individual who has to be able to afford to buy insurance in the private individual market, and that individual is going to get $1,000 tax credit. That is not going to solve the problem.

Mr. Speaker, people who do not have health insurance, it could cost them $5,000 or $6,000 a year to buy a policy; and they are not able to shell $4,000 or $5,000 out of pocket because they are going to get a $1,000 tax credit when their income is somewhere under $30,000 a year, basically under 15, and it phases down to 30. It is not going to happen.

This policy will not accomplish something. I do not want to be critical of something that is being proposed, I wish it would move; but what needs to be done is to expand the number of people that can get health insurance through some of the government programs.

Mr. Speaker, we looked at the problem of the uninsured in our task force, and the biggest group were children and the second group was near elderly, people over 65 but not eligible yet for Medicare. We tried to adjust the problem of the children through the CHIP program, and that basically provides health insurance at government expense and it has been great. It has enrolled millions of kids around the country that did not have health insurance.

Now you have to expand that program to the adults. In other words to households, to the adult parents, if you will, of those children, to other people in those lower-income brackets that are working but are not eligible for Medicaid regardless if they have children. That is the type of thing that should be done: expand on the CHIP program to include the parents, and even include single people who cannot afford to buy health insurance in the private individual market and are not going to be able to do it with a $1,000 tax credit. That is what the Democrats have been proposing. I do not see any movement in that respect.

The other thing that the Democrats have said, with regard to the near elderly, the people between 55 and 65, is that they be able to buy into Medicare for a standard premium every month or every year. That is another way of trying to address that problem.

But if we keep getting hung up on the ideology that the Republicans and the President have that everything the government does is not good, and the only answer is to throw a tax credit here or there, we are not going to cover any more of the uninsured. That is my fear right now.

I know that we have other things to get to tonight, and certainly the AIDS issue is super-important.

Mr. Speaker, I do want to say in conclusion, these health care issues, we as Democrats are going to continue to bring up frequently over the next few weeks because we do want to see action, and we are not seeing it on the part of the Republican leadership or the President.

TAX CUTS AND PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore (Mr. ISSA). Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, I want to talk a little bit tonight about two issues: first, about the tax cuts that passed the House and the Senate just before Memorial Day recess; then I will talk a little bit about the patients' bill of rights.

Mr. Speaker, I remember in early 2000, it was before the Iowa caucuses, it was cold, I remember, and I was traveling around the State of Iowa, my home State, with then-Governor Bush.

We had spent the morning together, and then returned to Des Moines where he was going to address the Des Moines Chamber of Commerce and give a major address on cutting taxes.

So Governor Bush asked me if I would sit in and listen to him give his speech in preparation. There was just myself and one staffer. We were at the Marriott Hotel in Des Moines, and they had the rest of the doors closed off. Then-Governor Bush practiced his speech. I sat there listening to at that time Governor Bush lay out his tax cut plan.

Afterwards the Governor invited me upstairs and we had a hamburger together, just the two of us. Then-Governor Bush asked me, Well, what do you think? Well, we had been through here in the House a major tax cut bill not too long before that. It was in the range of about $790 billion, and President Clinton had promised a veto of that bill. In addition, we were doing that tax cut not in the context of a budget plan, and certainly not in the context of how much we were going to reduce the national debt.

Once President Clinton declared that he was going to veto that tax cut, then it gave free rein to every Member of this House and the other body to add every piece of special-interest tax cut legislation they could to that bill. It became what we would call here in Washington a Christmas tree on which Members could hang every little piece of special-interest ornamentation, with the full realization that in the end there would be no harm because the President said he was going to veto that bill.

Mr. Speaker, sure enough, the final project, the bill, it was full of special-interest provisions. And so in the light of that, when then-Governor Bush asked me over our cheese burgers what I thought of his bill, I said, I think it holds together. You do it in the context of reducing some debt, providing for some educational funding, and it will be okay. But my one piece of advice would be keep it free of all of those special-interest perks and special-interest items that got added to the last bill we dealt with. Focus on eliminating the marriage penalty tax. Focus on killing the death tax. Focus on reducing rates and make it a progressive cut. And if you handle that, if that is what the bill is, and it does not have all of these special-interest perks, then I think the American public is going to be happy with it.

Then-Governor Bush said I assure you, I will do everything in my power if I am elected President to make sure that we do not load that bill up with a bunch of special-interest provisions that expand that Tax Code out, little pieces of tax legislation that act for individual families or individual businesses. We will work to keep that out and keep it clean. You know what, Mr. Speaker, that is what we did.

Now, I would be the first to admit that I have not read every single line of that tax cut. To be quite frank, unless you have the whole Tax Code with you and can reference things, it is difficult to read and understand what every single sentence means. But I do know that a whole bunch of people have been looking at that tax cut, the one that we just passed, and the one that this week the President in a Rose Garden signing ceremony is going to sign into law.

There was a report in the New York Times just a few days ago that said they could only find one item that was a special-interest item in the Tax Code, and that was a repeal of a prior special-interest item for JCPenney. So the