

later than the second legislative day after adoption of this motion.

MOTION TO INSTRUCT CONFEREES ON H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

Mr. KIND. Mr. Speaker, I offer a motion to instruct.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

Mr. KIND moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 1 be instructed as follows:

(1) The House recede to the Senate on the provisions to guarantee access to prescription drug coverage under section 1860D-13(e) of the Social Security Act, as added by section 101(a) of the Senate amendment.

(2) To reject the provisions of section 501 of the House bill.

(3) The House recede to the Senate on the following provisions of the Senate amendment to improve rural health care:

(A) Section 403 (relating to inpatient hospital adjustment for low volume hospitals).

(B) Section 404 (relating to medicare disproportionate share adjustment for rural areas), but with the effective date applicable under section 401(b) of the House bill.

(C) Section 404A (relating to MedPAC report on medicare disproportionate share hospital adjustment payments).

(D) The following provisions of section 405 (relating to critical access hospital improvements):

(i) Subsection (a), but with the effective date applicable under section 405(f)(4) of the House bill.

(ii) Subsection (b), but with the effective date applicable under section 405(c)(2) of the House bill.

(iii) Subsections (e), (f), and (g).

(E) Section 414 (relating to rural community hospital demonstration program).

(F) Section 415 (relating to critical access hospital improvement demonstration program).

(G) Section 417 (relating to treatment of certain entities for purposes of payment under the medicare program).

(H) Section 420 (relating to conforming changes relating to Federally qualified health centers).

(I) Section 420A (relating to increase for hospitals with disproportionate indigent care revenues).

(J) Section 421 (relating to establishment of floor on geographic adjustments of payments for physicians' services).

(K) Section 425 (relating to temporary increase for ground ambulance services), but with the effective date applicable under the amendment made by section 410(2) of the House bill.

(L) Section 426 (relating to appropriate coverage of air ambulance services under ambulance fee schedule).

(M) Section 427 (relating to treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital).

(N) Section 428 (relating to improvement in rural health clinic reimbursement).

(O) Section 444 (relating to GAO study of geographic differences in payments for physicians' services).

(P) Section 450C (relating to authorization of reimbursement for all medicare part B services furnished by Indian hospitals and clinics).

(Q) Section 452 (relating to limitation on reduction in area wage adjustment factors

under the prospective payment system for home health services).

(R) Section 455 (relating to MedPAC study on medicare payments and efficiencies in the health care system).

(S) Section 459 (relating to increase in medicare payment for certain home health services).

(T) Section 601 (Increase in medicaid DSH allotments for fiscal years 2004 and 2005).

(4) The House insist upon the following provisions of the House bill:

(A) Section 402 (relating to immediate establishment of uniform standardized amount in rural and small urban areas).

(B) Section 403 (relating to establishment of essential rural hospital classification).

(C) Subsections (a), (b), (d), and (e) of section 405 (relating to improvements to critical access hospital program).

(D) Section 416 (relating to revision of labor-related share of hospital inpatient pps wage index).

(E) Section 417 (relating to medicare incentive payment program improvements).

(F) Section 504 (relating to wage index classification reform).

(G) Section 601 (relating to revision of updates for physician services).

(H) Section 1001 (relating to medicaid disproportionate share hospital (DSH) payments).

Mr. KIND (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

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

There was no objection.

The SPEAKER pro tempore. The gentleman from Wisconsin (Mr. KIND) will be recognized for 30 minutes, and the gentleman from Pennsylvania (Mr. GREENWOOD) will be recognized for 30 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. KIND).

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

Mr. Speaker, what this motion to instruct basically states is asking for some fairness and some equity in regards to the rural health care providers during the Medicare reform conference discussions that are taking place right now.

Mr. Speaker, rural America is often called the backbone of our country, and rightly so. It is rural America where so many of our parents and grandparents grew up, and it is to rural America that many of our veterans, teachers, and farmers retire.

There are 9 million Medicare beneficiaries in rural communities, and these seniors tend to be older. They tend to be sicker. They tend to have a little less money than those in urban communities. Rural seniors are in great need, and we must be sure that any Medicare bill does not leave these citizens out in the cold.

□ 1845

Yesterday, the House voted on an identical motion offered by my good friend the gentleman from Texas (Mr. STENHOLM). Unfortunately, the motion was defeated, 202 to 213, with 19 Members absent. We are hoping to give

those absent Members another chance to come and vote and participate in this discussion, and hopefully then have the votes to prevail on this motion to instruct.

There are many Members on both sides of the aisle, Mr. Speaker, that come from rural areas, from rural districts. I do not for the life of me understand why a Member from a rural area would oppose a motion to instruct on this basis. I think it makes a lot of sense.

This is not an ideological or partisan issue, this is a geographic issue, and we are asking for some fundamental fairness and some equity in dealing with rural health care providers.

I believe Medicare recipients deserve a prescription drug plan under Medicare, and I believe that all seniors, regardless of their location, should have access to affordable, stable drug benefits. H.R. 1, however, lacks a guarantee that seniors living in rural areas will have access to such a plan.

Rather than gaining a drug benefit under Medicare, seniors would have to join a managed care plan or purchase a private drug-only plan. For rural seniors, only 19 percent of whom had access to a Medicare-managed plan in 2003, this could be disastrous. In effect, seniors in rural areas would be subsidizing prescription drugs for others, but would not get a drug benefit plan of their own.

I am not prepared to tell seniors in my district in western Wisconsin that some seniors will be getting a drug benefit, when they will not.

The Senate Medicare bill, recognizing the instability of private plans in rural areas, provides a fallback, meaning that traditional Medicare would offer its own prescription drug plan to areas with fewer than two private plans available to Medicare recipients. I urge the conferees to recognize the importance of offering prescription drug plans to all Medicare enrollees and to accept the Senate provisions.

Yesterday, some of my colleagues on the other side of the aisle argued that the instructions in this motion would lead to greater spending and higher deficits. I am committed to being fiscally responsible at all times and reducing the deficit, and this motion does not call for exceeding the budget limit of \$400 billion allotted for this Medicare reform bill. Rather, this motion instructs the conferees to carefully assess their priorities in allocating the \$400 billion. I hope that this dispels any confusion over the costs advocated by this motion, and I hope that my colleagues across the aisle will be able to join in supporting it.

We have seen too many rural hospitals close, over 470 in the last 25 years alone, and rural hospitals all over the country are in danger of being forced to shut their doors forever. Currently hospitals receive full inflation or market basket payments for inpatient and outpatient services. H.R. 1 would reduce hospital payment updates

for the next 3 years, which the CBO estimates would lead to a \$12 billion loss to hospitals over the next decade.

Currently over 57 percent of hospitals in America lose money when serving Medicare patients. We cannot ask hospitals to continue to accept Medicare payments that are below the cost of delivering the care they provide. The Senate bill makes no such cuts to the market basket payments and would keep rural hospitals in business. I urge the conferees to reject the House provision and accept the Senate provisions.

Geographic disparities in Medicare reimbursements disproportionately affect rural providers. In my State of Wisconsin, providers are paid 25 percent less on average per Medicare beneficiary. The motion encourages the conferees to adopt the best-world provisions in both bills. These provisions go a long way to reduce geographic disparities.

Physicians and specialists are scarce in rural areas. In fact, less than 10 percent of physicians practice in non-metropolitan counties. It is not surprising, given that rural providers consistently receive lower reimbursement rates than providers in the rest of the country.

These providers who do deal with the unique challenges presented by health care in rural areas are the pillars of our communities, and fair payments to rural providers mean quality health care for our Nation's seniors.

Physicians in rural communities see a large percent of Medicare patients. This motion instructs conferees to include the best provisions of the Senate and House bill. We must insist that rural providers and beneficiaries are protected and that critical-access hospitals are maintained and improved.

I would be disappointed if my colleagues on the other side of the aisle did not join in voting for this motion and supporting providers in their communities. Yesterday's close vote on a motion identical to this one shows that many of us are concerned about the crisis of health care in rural areas. By again offering this motion, and by dispelling the myth that these instructions would lead to a more expensive Medicare bill, I hope that those Members who were absent yesterday, as well as those Members who truly do care about the state of rural health care in our country, will cast a vote in favor of this motion.

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

Mr. GREENWOOD. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Colorado (Mr. MCINNIS), a member of the Committee on Ways and Means.

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

I also wanted to note at the beginning of my comments that the gentleman from Wisconsin (Mr. KIND) is a gentleman, he is well respected, but I adamantly disagree with the statements that he has made.

Let me say that I represent a large rural district, and I know something about rural hospitals, and I know something about a government-run plan. The proposal that the gentleman from Wisconsin (Mr. KIND) is asking to instruct the conferees on is simply a government-run program. It is a repeat of HILLARY CLINTON.

So while I have high regards for the gentleman from Wisconsin, I could not disagree more. The motion that he has got clearly asks for a government-run prescription drug plan. It will give us a government bureaucracy that will increase its influence and adopt a philosophy of even bigger and bigger government.

Now, our government currently has government health care programs, whether you look at the VA or Medicare or some of these others things, and they have not done a very good job of it. What kind of encouragement exists out there for us to expand this program? How can you want to enlarge it? It will not work. The intent is good. The result will be a disaster.

The motion also provides an unprecedented inflationary increase as to hospitals and other health care providers, which forces the conference to quickly exceed the \$400 billion allocation in the budget resolution. It is always easy from this House floor to propose all kinds of money going out to the Nation, but the fact is somebody has got to write the check, and right now we do not have the balance to write that check.

So the motion to instruct defeats the purpose of the conference committee, which has already come to agreement on several provisions contained in both bills. Let me kind of highlight that for the remaining time.

These conferees have been working very, very hard. This is a very tenuous agreement, if we are, in fact, able to come up with agreement. To interject at this late point in the game a proposal that would quickly exceed the ceiling in cost, and, on top of that, invoke clearly a large government-run health care program just like the Clinton program will defeat our purpose.

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

Mr. Speaker, that large government-run program is called Medicare, a very successful and highly popular program for seniors throughout the country.

Mr. Speaker, I yield 4 minutes to my friend the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I rise in strong support of the Kind motion to instruct. It was amazing listening to my colleague from Colorado, because his statement has no relationship whatsoever to this motion to instruct.

The Kind motion will include a fallback provision to ensure that seniors have prescription drug coverage where private plans choose not to participate. It has nothing to do with increasing the size of any program. It just says if the program that is in the House bill does not work, there is a fallback.

Congress has a responsibility to guarantee this very important component of health care for all seniors, not just those who happen to live in an area where a private drug plan is offered. Contrary to what you may have heard, and we just heard it a moment ago, this motion will not require a government prescription drug plan or bust the budget. The Medicare fallback would only apply if the private sector fails to provide prescription drug plans in rural areas.

The Kind motion to instruct also includes important improvements to rural health care providers. Because of the very high proportion of elderly in rural areas, Medicare is a very large and critical source of payment for rural health care providers. Inadequate Medicare payments to rural hospitals and other rural health care providers over the last several years have only deepened the challenges to quality health care.

The Kind motion to instruct would take the best provisions. It was amazing listening to all of this stuff that is going to happen in this bill. We are saying take the best provisions in the House bill and the best provisions that have passed the Senate and make sure that those get in the final bill, because rural America can stand no less.

The Kind motion to instruct also rejects the House provisions that would cut hospital inflation increases. Hospitals cannot rebound from a \$12 billion payment cut from rate of increase. I want to be sure everybody understands rate of increase. But that is not the problem. The problem is rural areas have not kept up over the last 10 years, and, therefore, unless we have the market basket as designed, rural hospitals are going to find themselves in an even deeper hole.

Hospitals are already operating on a thin profit margin. They are hurting. One out of three hospitals in America is operating in the red. More than 57 percent of all hospitals lose money under the Medicare program. A reduction in the market basket would wreak havoc on our Nation's hospitals, particularly the more vulnerable rural hospitals.

That is why we come again to the floor again tonight saying, please take a look. And to those on the other side of the aisle who did not vote yesterday on it, take another look. Look at your district. Listen to your hospitals, listen to your constituents, and see if they do not agree.

Again, let me repeat, the myth that this is a budget-busting motion, it is not. We agree with the \$400 billion, period. I do not want to hear any more of this "budget-busting." That is right out of the playbook that has got us into \$560 billion deficits today.

We agree. We are just saying take the \$400 billion, reprioritize, and make certain that rural hospitals get a fair shake. That is all that we are saying.

Even with stronger rural provisions, a Medicare fallback and no reduction

in the hospital market basket update, the bill passed by the other body stays within the \$400 billion. They do it; we can do it. We just disagree with some of the priorities of some of the folks on the other side of the aisle, and we believe that most Members of rural areas, most Members who have rural hospitals, agree with this basic presumption that we ought to have an instruction.

Hospitals are important. The crisis has, of our rural hospitals, we have closed 470 in the past 25 years. I have several in my district hanging by a thread. If you succeed in doing what you are arguing for, they will bust that thread.

Please support the Kind motion to instruct. It is good for 9 million rural Medicare beneficiaries and will put us on a path toward economic stability.

Mr. GREENWOOD. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, first off, let me suggest to the gentleman, my friend the gentleman from Wisconsin (Mr. KIND), that we take his motion seriously. Having said that, we all know that motions to instruct conferees are only that. They have no ultimate effect.

The fact of the matter is the negotiations have been ongoing in the conference committee, and whether this motion passes or does not pass, the conferees on the part of the House and the part of the Senate, the Republicans and the Democrats, are and have been and will be continuing to negotiate all of these issues, and they will all be negotiated in the context of all of the other issues that they are negotiating.

But having said that, I also want to, at least in this point in the argument, assume that the gentleman's arguments are sincere, and I would like to address them.

First off, with regard to the argument that we need a fallback, a government-run fallback, for the prescription drug program, the gentleman's point is well taken. We do, and we should have, and we should guarantee that, in every region of the United States of America, every senior will have access to a good and affordable prescription drug plan.

We believe that the bill as adopted by the House already does that, that the incentives that we give the Secretary to offer to the plans, in fact, does guarantee that there will be at least two programs, two plans, in every district, in every region, and, in fact, the CBO expects within the first year it will be available, the plan will be available, to 95 percent of seniors; in the second year, 99 percent.

On the second issue, the gentleman from Wisconsin argues that we need to pay hospitals a fair amount, and, indeed, we should. We relied upon the Medicare Payment Advisory Commission, MedPAC, who said what would be fair based on all of the data available is to include a 3 percent market basket update as opposed to a 3.4 percent, as the gentleman from Wisconsin argues.

Having said that, what the gentleman does not take into consider-

ation is that is not the only increase in payments to hospitals available under our legislation. Looking at Iowa, for instance, a very rural State, they get a 1.6 percent increase under the standard amount, an additional 0.8 percent for the labor share, and 0.1 percent for medical DSH increases, which gives the hospitals in Iowa actually a 5.5 percent increase as opposed to a 3 percent increase. In Oklahoma, that number comes to 5.7 percent; the same in Montana, 5.7 percent; South Dakota, a very rural State, as rural as you can get, 5.4 percent.

□ 1900

So we think that the gentleman's objective in making sure that hospitals get healthy increases and reimbursements is, in fact, met by the legislation that this House passed and is continuing to be negotiated in the conference committee.

On the third major point of the gentleman's motion, he suggests that each and every rural provider increase in either the Senate bill or the House bill will be incorporated into the conference committee. The gentleman's objective is to make sure that the benefits are available in the rural areas. We all share that objective. But I would note that the House-passed bill itself included nearly \$25 billion increases in payments to rural providers, which will help rural hospitals and physicians, among others, continue to provide care to rural Americans.

So on the substance, I believe that the bill, as adopted by the House, meets the gentleman's objectives already. Secondly, again, a motion to instruct, while fun to debate, actually will have no impact on the negotiations themselves. I think we ought to let those negotiations continue and allow the conferees to come to an agreement, and I believe that they will, that this House can adopt and send to the President.

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

Mr. KIND. Mr. Speaker, I yield 4 minutes to the gentleman from Ohio (Mr. BROWN), a true champion of rural health care providers and rural health care patients.

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Wisconsin for yielding me this time, and I thank him for his good work advocating rural health care. I thank the gentleman from Pennsylvania (Mr. GREENWOOD) for his epiphany and his conversion in supporting the fallback provision, something he voted against in committee; and I hope that he will let the conference committee, particularly the Republican conferees of his party, know that he does, in fact, support the fallback provision. I hope that that will move the Medicare bill along perhaps better.

I rise in support of the gentleman from Wisconsin's (Mr. KIND) motion to instruct on behalf of retirees living in rural America. Yes, we are continuing

to push this body to take a stand on behalf of retirees living in rural America. And yes, we voted on the same motion yesterday. But anyone who thinks Congress always gets it right the first time just does not know much about Congress.

Last week, during our first round of debate on this motion, my colleague argued against it. He expressed concern that we actually have to spend money to fulfill our commitment to rural retirees. Apparently, Congress can afford to cut \$3 trillion from Federal tax revenues, overwhelmingly from the wealthiest, most privileged taxpayers, but cannot afford to help retirees in Chillicothe, Ohio, secure the same basic health care services as retirees in Columbus, Ohio.

In his State of the Union address, President Bush called Medicare the binding commitment of a caring society. Does that commitment extend to rural America, or does it not? We have an obligation to pay health care providers adequately for the care they provide. We cannot pretend in this body that the financial challenges rural providers face are the same as those of urban providers. Ideally, the health care system would be thriving in rural America. Realistically, the health care sector is faltering in rural America.

A disproportionate number of seniors live in rural areas. Medicare is the lifeblood of rural health care. That is just the way it is. We can either ignore the impact of inadequate Medicare financing, or we can do something about it. What we definitely should not do is, as this body does all too often, simply pay lip service to the problem. The House Medicare bill simultaneously increases and reduces reimbursement to rural hospitals. That is paying lip service to the problem.

The Kind motion, the motion from the gentleman from Wisconsin, my friend, instructs conferees to move in one direction only, the right direction, and pay hospital rates that keep up with inflation. This motion instructs conferees to ensure there is a Federal fallback insurance program for areas of the country in which no private plan is available, something that we all think is essential.

While this provision is particularly important for rural beneficiaries, it is also one of the most important for any Member of Congress who really is worried about wasting constituents' tax dollars. It is basic economics. Absent a Federal fallback provision, which I am glad to see the gentleman from Pennsylvania (Mr. GREENWOOD) now supports, the private insurance industry will have a monopoly over Medicare prescription drug coverage. Do my colleagues think the cost of coverage to taxpayers will be higher or lower under those circumstances, when the insurance industry has a monopoly?

In the 6 years that the Medicare+Choice HMO program has been in effect, has an HMO ever told Congress, hey, we do not need any

more money, you are paying us enough? Year after year HMOs demand more money from taxpayers even though, in fact, we were already overpaying them. Do not take my word for it; ask the nonpartisan General Accounting Office.

Medicare+Choice has inflated Medicare spending, draining precious tax dollars from the program. Making Medicare and making U.S. taxpayers fully beholden to HMOs is not going to improve the situation.

So, Mr. Speaker, whether our goal is to refrain from wasting tax dollars or to fulfill the Nation's commitment to rural Medicare beneficiaries, or, I hope, both, I urge my fellow Members to support the Kind motion.

Mr. GREENWOOD. Mr. Speaker, I yield myself 30 seconds to say that I am sure my friend from Ohio did not mean to misspeak with regard to my previous comments. What I said is that both the gentleman from Wisconsin (Mr. KIND) and Members of this side of the aisle want to make sure that there is a guarantee that our seniors in all regions have access to a plan. We think we do that adequately by the requirement that the Secretary provide incentives. The gentleman from Wisconsin (Mr. KIND) offers another way to do it, but we have the same goal.

Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I rise in opposition to the Kind motion.

This motion would allow the Department of Health and Human Services to offer a Medicare prescription drug plan. In fact, there is no need for this type of government-run fallback because the House has already passed legislation that guarantees that every Medicare beneficiary will have a choice of at least two Medicare prescription drug plans and be able to fill their prescriptions at any pharmacy that they choose.

The motion also instructs the conferees to recede to the Senate and remove the hospital market basket update adjustment contained in the House bill. I would note for my colleagues that we are not cutting hospital reimbursement.

According to the Medicare Payment Advisory Commission, hospitals make a 10 percent profit for Medicare inpatient services and a 5 percent profit, on average, for all services provided to Medicare patients. The Medicare Payment Advisory Commission unanimously advised Congress to increase payments by 3 percent, which is what the House bill does.

Finally, this motion would instruct conferees to accept every rural provider increase contained in both bills.

Mr. Speaker, I would just add parenthetically that if our friends on the other side of the aisle were really concerned about rural providers and rural hospitals, they would encourage their colleagues in the other body to take up and pass the legislation that we passed last March, which was the Greenwood

bill, H.R. 5, that limited noneconomic damages and medical liability lawsuits, and I believe that would return more money to the system.

But this motion is unnecessary. The House has already recognized the need to ensure that rural Medicare providers are paid fairly. In fact, the House bill contains a \$24.9 billion increase in payments to rural providers, which would help rural hospitals and physicians continue to provide care to rural Americans.

I think the House bill strikes the right balance between providing a meaningful prescription drug benefit and helping ensure that providers, especially those in rural areas, have the incentives to continue to serve Medicare beneficiaries.

I would also note that the conferees have reached agreement in a bipartisan, bicameral basis on a number of issues that would be reopened under this action. Do we really want to tell the conferees to just start over? I do not think so.

Mr. Speaker, we should allow the conferees to work out the differences between both bills. There are significant differences, but they are working hard to do that. Both Chambers have made a significant commitment to helping rural providers. I have every confidence that they will develop a sound policy.

Mr. KIND. Mr. Speaker, I yield 3 minutes to the gentlewoman from Oregon (Ms. HOOLEY), a true champion of seniors in rural America and in her congressional district.

Ms. HOOLEY of Oregon. Mr. Speaker, I thank the gentleman from Wisconsin for yielding me this time. I rise today in strong support of the Kind motion to instruct conferees.

Let me just say a couple of words about instructing conferees. I have heard that it does not make any difference. Well, in fact, it does make a difference. The conferees do pay attention when this body, the majority of this body, says it is important, please pay attention to rural health care, the reimbursement rate, and the fact that our hospitals are closing.

Across Oregon, seniors tell me their top concern is the high cost of prescription drugs and the lack of coverage for these lifesaving medicines under the Medicare program. I believe it is time for us to pass a bill that will give relief to seniors, but that bill cannot neglect the needs of rural Medicare beneficiaries.

Limited access to care is a growing problem for those who live in rural areas, particularly Medicare beneficiaries who may have to drive great distances to receive care. In Oregon, a recent study showed that 55 percent of primary care physicians no longer accept Medicare patients or limit the services they provide to those patients. For many physicians in rural communities, their practices are dependent on Medicare patients, and yet they do not receive fair payments for their serv-

ices. Rural providers are consistently hurt by lower reimbursement rates. This motion instructs conferees to include the best of the rural provisions in both the House and the Senate bills and would improve reimbursement rates for rural physicians.

Rural hospitals are also being hit by disparities in Medicare payments. You have heard it before and I will say it again. In 25 years, more than 470 rural hospitals have closed. Many are now in danger of being forced to shut their doors. Currently, hospitals receive full inflation payments for in-patient and outpatient services. The House-passed prescription drug bill would reduce hospital payment updates for the next 3 years, costing hospitals an estimated \$12 billion. If we thought we saw a lot of hospitals close in the last 25 years, we are going to see a lot more close in the next few years if we do that.

This cut would be devastating to our hospitals, particularly, again, to those in rural areas. If we are serious about modernizing the Medicare program, we must ensure that we fairly and adequately represent rural seniors.

Mr. Speaker, I urge my colleagues to support this important motion to instruct conferees and assure that our rural Medicare beneficiaries receive the quality health care that they deserve.

Mr. GREENWOOD. Mr. Speaker, I yield 4 minutes to the gentleman from New Jersey (Mr. FERGUSON).

Mr. FERGUSON. Mr. Speaker, I rise in opposition to the motion.

This motion would allow the Department of Health and Human Services to offer a government-run prescription drug plan. There is no need for this type of government-run fallback because the House legislation that we passed earlier this year guarantees that Medicare beneficiaries will have a choice in at least two Medicare prescription drug plans. We do that by offering incentives to private sector providers to offer that coverage; and they, in turn, assume some of that risk. The standard subsidy would be 73 percent to a private provider, but that private provider would assume the rest of that risk. This motion would have the government assume all of the risk; and, of course, what we know is when the government is assuming the risk, it is the American taxpayer who is the backstop; it is the American taxpayer who ends up really assuming the risk.

A second point. We have talked about the rural provider provisions of these bills. This motion to instruct would have the conferees accept every rural provider increase contained in both bills. What we have heard is that they say only the best provisions, only the best rural provisions of each bill. Well, we know that really means every rural provision of both bills. My friend, the gentleman from Texas, before said, well, this would not actually increase, it would not bust the budget, it would not increase the cost. Well, clearly, accepting every rural provision from both

of these bills would cost tens of billions of dollars more than is already provided.

What we have heard from the sponsor of this motion and the gentleman from Texas is, well, we are not talking about increased spending; we are just talking about reprioritizing; we are talking about moving the money around a little bit. Well, what that really means, put in English, that means we are going to increase the spending for the rural providers, we are going to increase that money, that package to rural providers; but we are not going to change the total amount of spending. We are going to stay at the same price tag. Where is the money going to come from?

□ 1915

It is going to come from the drug benefit to everybody else. So either you are going to bust the budget and bust the price tag on this and jack up government spending, or you are going to take money away from the prescription drug benefit which is at the heart of this legislation.

This motion is unnecessary. This House has already passed and already recognized the need to ensure that rural Medicare providers are paid fairly. The bill that this House passed earlier this year contains \$24.9 billion, almost \$25 billion more, an increase in payments to rural providers, which will help rural hospitals and physicians, among others, continue to provide care to rural Americans.

This motion would mean that we have to reallocate funds away from beneficiaries and toward providers. I do not support that. I think the House bill that we passed earlier this year strikes the right balance between providing a meaningful prescription drug benefit and helping to ensure that providers, especially those in rural areas, continue to serve Medicare beneficiaries.

Finally, let me just say that, again, as I know some of my colleagues have mentioned, the House and the Senate conferees have reached agreement on a number of issues in a bipartisan, bicameral way on a number of issues that would be reopened under this motion. We are running out of time. Our session, this session, is running out of time. We want to finish this bill. We want to finish it this year. Do we really want to go back and tell our conferees to start over from scratch? I do not want to do that.

Mr. Speaker, we should allow the conferees to work out the differences between these bills since both Chambers have made a significant commitment to helping rural providers, and I have every confidence that, in the end, they are going to develop a sound policy.

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

I am sure the gentleman from New Jersey must realize that the conference and negotiations are ongoing and that these very decisions have yet to be

made. I am surprised by the rhetoric on the other side that they do not recognize that 39 Republican Senators recently voted for a Medicare prescription drug fallback provision. They had to have known what they were doing on that vote.

Mr. Speaker, I yield 6 minutes to the gentleman from Alabama (Mr. DAVIS), one of the youngest and brightest minds of the United States Congress.

Mr. DAVIS of Alabama. Mr. Speaker, I thank the gentleman from Wisconsin for his compliments and for yielding time to me today.

I want to begin with the comments of my good friend from New Jersey because I think that they reflect a fundamental divide on how our two parties look at this issue. The gentleman from New Jersey is 100 percent correct when he says that the Medicare plan being contemplated would theoretically allow a choice for seniors. He is 100 percent correct when he says that seniors would have the ability to elect between a private managed care plan and Medicare. He is 100 percent correct about the theory and about what is written in this plan. But I come from the Seventh District of Alabama where a significant number of our seniors live in a world very different from a lot of the people who sit in this body. A lot of the seniors in my district live in a space where they are illiterate. They live in a space where they are not able to interpret the difference between a plan A and a plan B. They have trouble navigating every single aspect of their daily lives. Some of them cannot even fully understand their own prescriptions, but yet it is true they will have a theoretical choice as to which plan is better for their interests.

One thing that I would hope that this whole body would agree on, Mr. Speaker, is that we do not need to provide a benefit that some people in this society will enjoy but that other people will not enjoy because of their station and place in life. I care, as I know my colleagues on the other side of the aisle care deeply, about the seniors who do not have the education, who do not have the background to make the kinds of choices that they will need to make. The problem with this plan, unless it is fixed and made better by the Kind motion, is that it will force our seniors to have to make a fundamental choice, and if they choose wrong, they could find themselves without adequate coverage.

There is a deeper problem. Only 19 percent of the seniors in rural America live in an area that has access to a ready managed care plan; less than 20 percent. When the seniors who are listening tonight or the seniors who follow this debate hear that we are passing a prescription drug benefit, they imagine that it is something that will be executed, they imagine that it is something that can be implemented in a way that favors and is fair to them. They do not know about the maze of choice that is in front of them. We can

talk all we want in a theoretical sense about the values of choice in our society. We can talk all we want in a theoretical sense about letting our seniors and letting the market combine to make good, efficient choices. This is not always an efficient world.

There is no dispute in this Chamber that after the next several years, a significant number of seniors would potentially be left out of this plan. That is something that the Kind motion would fix. That may sound to some of my colleagues on the other side of the aisle like paternalism, but a lot of the seniors who live in my district do not want to have to navigate their own way for this set of choices. They do not see it as paternalism, they see it as government lending a helping hand to them.

This Medicare program that we have heard denounced tonight as being a "big government program," that we have heard denounced tonight as being another example of "rampant government," it happens to be an important part of the social safety net that we have in this country. The question is, do we tighten that net and make it stronger or do we allow significant gaps to form in that net?

As I moved around my rural district during the month of August, so many seniors said to me, Mr. DAVIS, I would rather have no plan than a plan that I don't understand and a plan that I won't benefit from. So many seniors said, I would rather see you all in the ivory towers in Washington, D.C., do nothing than do something that leaves me worse off. Those are the people that I want to speak to tonight, and those are the people I want to speak for tonight because we have to make sure that this is a plan that would be available to all of the seniors in this country who need it.

We can talk all we want about appropriating more money in the House bill for rural hospitals. We still do not give enough. The Senate does far better. Until we address the root of these unfair choices, we will leave our rural seniors worse off. So I support this motion tonight. I will close on this basic point. Most of us in our campaigns in 2002 endorsed the idea of a prescription drug benefit. Most of us go back to our districts and we brag about the fact that we support it. A lot of our friends and colleagues on the other side of the aisle are touting that fact in their campaign ads. A lot of our seniors remember just 15 years ago when this body purported to pass a catastrophic health benefit plan that did everything but provide adequate coverage, that did everything but improve their conditions in life. It may be that this part of the session is running to a close, it may be that the clock is ticking, but the nature of what the people elect us to do is to make hard choices. The nature of what the people elect us to do is to make adequate choices. And, yes, sometimes as paternalistic as our

friends may think it is, they sometimes elect us to make choices that will affect their lives.

So I urge my colleagues on both sides of the aisle to vote for this motion to close an unfortunate, but critical, gap that exists between our rural seniors and urban seniors.

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

I would compliment the speaker on his argument and suggest, though, that his constituents must be able to make choices, and thoughtful choices, because they chose him. And I suspect that if they are sophisticated enough to choose the previous speaker, they can probably choose themselves a good Medicare plan as well.

Mr. Speaker, I yield 5 minutes to the gentleman from Oregon (Mr. WALDEN).

Mr. WALDEN of Oregon. Mr. Speaker, I rise today representing the second largest district geographically in the Nation in the House, other than the five States that are only single-Member States, so I know something about rural health care. I spent 5 years on a community hospital board. I am still a private employer, so I see that side of health insurance. My in-laws are retired and face this battle about lack of medical prescription drug coverage under Medicare. My parents battled that until their death. They paid for their own prescription drugs out of their own pocket. The issue that we are trying to resolve here in this Congress is for the first time in 40 years expanding Medicare so that seniors can have access to affordable prescription drugs. It is not easy to do. It is not simple to do. It is very difficult to do, to get it right. But I think we are very, very close in getting it right this time.

We have passed the biggest rural health care package probably in the history of this House. We are adding \$25 billion in additional rural health care for the country in addition to what we already spend, \$25 billion over 10 years, for some very good provisions. In the committee I supported increasing the access to rural home health care, a 5 percent increase in payments. I have supported efforts to add additional funding for physicians to locate in remote and underserved areas in rural communities. In my State, though, while certainly these are all issues, the biggest issue I hear from medical providers is the runaway cost of malpractice insurance because of the claims and the litigation. That is driving specialists out of their specialties. I was in a community in my district this summer, a fellow who delivered babies says he is getting out of the GYN part of OB-GYN. They are not going to be dealing with that. We had five doctors deliver babies in one county in my district, and they are down to two, and those two are having their premiums subsidized now by the local hospital. We have passed medical malpractice reform in this House to try and make sure that people have access

to their doctors. It is time for the other body to act. I know many of my colleagues on the other side tonight could not support us on that. That is a problem in rural health care delivery as well that needs to be addressed.

But the crazy thing to me tonight is to hear that somehow we are not going to help seniors with this bill. We are spending \$400 billion over 10 years to provide a prescription drug benefit and additional help to our hospitals and our physicians in our rural communities, \$400 billion. Any dollar you take to spend somewhere other than prescription drugs comes out of our ability to help seniors most in need to provide prescription drugs. And so I think that is important to remember here. Those of us who have kids, they want everything in Toys R Us, but you cannot have everything in Toys R Us. You have to make choices. What we have chosen is to put the biggest benefit possible into those seniors most in need. That is why a senior, low-income, \$12,000 a year, will have their prescription drugs paid for other than a very small copayment. They will not have a premium. They will not have a deductible. They are covered. But if you are a Ross Perot and making \$65,000 or more a year, that benefit phases out. It is an irony to me to hear the other side talk about tax cuts for the rich, but they want free pharmaceuticals for the rich. I think with the limited resources we have, it ought to go to the poor, those in need.

Finally, this is not me, this is a Congressional Budget Office report that says under both acts, the House and the Senate bill, CBO estimates that all Medicare beneficiaries would have access to prescription drug coverage. This report goes on to say that in the House bill, CBO, the Congressional Budget Office, nonpartisan, independent, estimates that about 5 percent of the part D participants, that would be under this bill, would be enrolled in reduced-risk plans in 2006 with that share declining gradually in succeeding years.

We have heard a lot of political rhetoric tonight. CBO cuts to the chase. Both plans provide guaranteed access to prescription drugs for America's senior citizens. Both plans do that, the House and the Senate. We do it differently. We think on our side we do it more effectively, because in 23 years, if we do not change how Medicare operates, it goes completely in the red. I do not think Congress is going to let it go broke. The point is here, we are trying to create a new benefit with a new idea that says we can use market forces to drive down the cost of drugs so we can provide better care to the poorest seniors in America. That is what our bill does. That is what is being negotiated in a bipartisan, bicameral effort as we speak. This is not the time to upend that, nor is it the time to politicize it and end up another year going by without seniors having access to affordable prescription drugs.

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

Just quickly in response to the previous speaker, no one is trying to politicize this. We are just trying to work to produce the best product at the end of the day, especially for many of our rural seniors whom we represent in this body.

Mr. Speaker, I yield 5 minutes to the gentleman from Texas (Mr. SANDLIN), the foremost expert on the impact medical malpractice has on health care costs in this Chamber.

□ 1930

Mr. SANDLIN. Mr. Speaker, it is really pretty simple. Who is going to stand up for America's seniors? Who is going to stand up for rural health care? Who in this body will stand up for rural patients and rural doctors and rural hospitals over the HMOs? The answer is pretty clear.

Mr. Speaker, I join my colleagues in asking to instruct the Medicare prescription drug conferees to remember our Nation's 9.3 million rural Medicare beneficiaries and our rural hospitals and our rural doctors when they continue their critical deliberations.

The way this bill currently stands, it is nothing more, Mr. Speaker, than the old bait and switch. And everybody here knows that the Republican leadership has used smoke and mirrors to trick our seniors, to trick my seniors in east Texas into thinking they are getting a Medicare prescription drug plan while in reality forcing them to seek medication from private insurance companies and HMOs that will, number one, set the prices, and, number two, set the benefits. What a racket they have.

This is not any sort of Medicare prescription drug plan. What a misnomer. This is a plan to push our seniors, to forcefully shove them and their money into the HMOs.

Now, this official HMO enrichment plan that is pushed by the other side does not even pretend to address the needs of rural America. Mr. Speaker, as you know, and as has been mentioned, over 80 percent of rural Medicare beneficiaries today live in an area that private insurance companies do not and will not serve. And in my district it is even worse than that.

Mr. Speaker, I challenge my friends on the other side of the aisle to name me one insurance company in the United States of America, one, that wants to take part in this program. I would ask that a blank be left in the RECORD at this point, that a line be drawn right now so that our friends can insert in that blank the name of one insurance company, one in America. There is not one. They cannot fill it in, and the RECORD will remain blank.

What has history shown us about what happens when insurance companies, private insurance companies, get involved in Medicare? Medicare+Choice, the great managed care experiment of our seniors, should

have been named Medicare Minus Choice. After all, it has been a disaster.

Between 1998 and 2003, the number of Medicare+Choice plans dropped by more than half. It is not available. In Texas, over 313,000 Medicare Plus seniors were dropped by insurance companies since 1999.

Rural seniors simply do not have the same access to private insurance plans as our urban seniors. Knowing this, we have to include a government fallback option for areas served by less than two plans, because otherwise the plan is meaningless, and our friends know it.

Mr. Speaker, we also need to eliminate the premium support provisions in H.R. 1 that are scheduled to take place in 2010. It is unconscionable to market this prescription drug plan as equitable and universal when those folks that stay in traditional fee-for-service Medicare will see significant increases in their premiums under this so-called competition program. It is just outrageous.

What about our rural hospitals? What shape are they in? Mr. Speaker, 470 hospitals have closed in the past 25 years, and overall Medicare margins have shrunk every year since 1998, with 57 percent of hospitals that treat Medicare patients losing money. And we are going to cure that by taking more money away? That is our cure? That is our plan?

Under current law hospitals are slated to receive full inflation payments for inpatient and outpatient services. The House bill that is being proposed by our friends on the other side would reduce hospital payment updates in 2004, reduce hospital payment updates in 2005, reduce hospital payment updates in 2006. The reduction would cost hospitals an estimated \$12 billion. Well, in east Texas \$12 billion is a lot of money, and those are cuts to our rural hospitals.

Mr. Speaker, it is a matter of priorities. I choose to stand with America's seniors. I choose to stand with our rural citizens. I choose to stand with our hospitals and our doctors in making sure that we have access to affordable medical care. The HMOs seem to do just fine.

Now, I find it interesting, too, in closing, and I am not here to talk about malpractice, we could go on all day about malpractice, but it is interesting that today our friends are standing up for HMOs. And a few days ago in the medical malpractice debate they were standing up for insurance carriers.

It seems pretty clear who we stand up for in this House, especially on the other side of the aisle. They stood up just the other day for malpractice carriers against hospitals, malpractice carriers against doctors, malpractice carriers against our patients, malpractice carriers against everyone. The malpractice reform was just a trick, because while we passed malpractice reform, we capped what insurance com-

panies paid. We capped what they had to give to people. We capped the coverage needed by doctors. But we did not require in any respect whatsoever insurance carriers to bring down the premiums on our doctors. It is not there.

And in their model State, California, just in the last few weeks they have record increases, record requests for increases by the insurance companies who are protected by caps. Those caps do not work. And in States that have caps, they have premiums higher than in States that do not have caps.

It is just a sell-out to the insurance companies. It is a sell-out to the carriers on behalf of the insurance companies, against the doctors, against the patients, against the hospitals.

Mr. Speaker, it seems funny to me we always want to save money in this body and save money in health care by taking money out of the public and giving it to insurance carriers. That is a funny way that we save money, and it is simply an example of a lack of priorities.

Let us stand up for health care. The HMOs, the insurance carriers are doing just fine without our help.

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

Mr. Speaker, I want to thank the gentleman from Wisconsin (Mr. KIND) for offering the motion to instruct and for the temperate way in which he conducted his debate on the substance, as is his style. And the debate went pretty well like that until the previous speaker kind of laid down some political gauntlets. And I cannot resist the opportunity to respond.

The gentleman from Texas (Mr. SANDLIN) asked the question repeatedly, who will stand up for seniors, and who will not stand up for seniors. The historical record shows that Medicare was created in 1965, and in the 30 years that followed, the United States Congress failed consistently to get anywhere on the provision of a prescription drug benefit for Medicare beneficiaries.

As the previous speaker and earlier speaker said, there was an attempt 15 years ago when the Democrats controlled the House under Chairman Rostenkowski. It was immediately repealed. It was a dismal, dismal failure, a great disappointment to the seniors who had hoped for something that would be useful for them.

This Congress, where we happen to have a Republican majority in the House and a Republican majority in the Senate and a Republican in the White House, we have for the first time in the history of the United States brought ourselves to the point where we are poised to provide the senior citizens of this country a prescription drug benefit, and they need it.

We have all received letters over and over again from seniors who are forlorn and despairing over the fact that they are suffering from a variety of ill-

nesses. They go to the doctor, they get a prescription, and they cannot fill that prescription. I remember a poignant letter from one of my constituents, an elderly woman from Bensalem, who said, I have eight prescriptions. I can afford to buy the ones that will keep me alive. I just cannot afford to buy the ones that will make my life worth living, and that letter has remained in my mind ever since, and it had driven me to work as hard as I can with colleagues interested in accomplishing this goal on both sides of the aisle to get a prescription drug benefit done.

It is hard. The reason it had not been done for 30 years is because it is so difficult, because it is so complex, to figure out how to do this in a way that is affordable, that maximizes a benefit for the very poor, that provides something worth happening for the middle class, asks a reasonable contribution from them, still does not create a disincentive for employers to continue to provide a prescription benefit for their retirees.

To deal with all of the rural issues, all of the provider issues is extraordinarily complicated and very difficult to do. If this body were 100 percent Republicans, it would be hard to do. If it were 100 percent Democrats, it would be hard to do because it is tough policy.

I think we are on the verge of being there. Our negotiators in the conference are working with the staff day and night to get us there. I believe that they will succeed. I again respect the gentleman from Wisconsin because he is bipartisan by nature. We ought to keep this debate bipartisan, consistently. That is the only way we will succeed in doing this. There are not enough Democrats to pass a Democratic plan. There are not enough Republicans to give the seniors this benefit with Republican votes only. We need to have a bipartisan bill. We will have a bipartisan bill.

On the subject of medical malpractice, the Democrats sat down year after year while the physicians of this country are going out of the profession, and we passed a bill in this House. It was a good passed bill. We did it in a bipartisan fashion, and if the Senate would come up with anything at all, we could go to conference on that bill, and it would also bring down the costs of medicine in health care in the United States.

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

The SPEAKER pro tempore (Mr. COLE). The gentleman from Wisconsin's time has expired.

Mr. KIND. Mr. Speaker, I would ask passage of this motion.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to instruct.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to instruct offered by the gentleman from Wisconsin (Mr. KIND).

The question was taken; and the Speaker pro tempore announced that the yeas appeared to have it.

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2657) entitled "An Act making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004, and for other purposes."

MOTION TO INSTRUCT CONFEREES ON H.R. 1588, NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mr. CROWLEY. Mr. Speaker, I offer a privileged motion.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

Mr. CROWLEY moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 1588 be instructed to agree to the provisions contained in paragraphs (3) and (4) of section 1074a(f) of title 10, United States Code, as proposed to be added by section 701 of the Senate amendment (relating to health care for members of reserve components).

The SPEAKER pro tempore. Pursuant to clause 7 of rule XXII, the gentleman from New York (Mr. CROWLEY) and the gentleman from New York (Mr. MCHUGH) each will control 30 minutes.

The Chair recognizes the gentleman from New York (Mr. CROWLEY).

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

This motion is an easy one and one that should be accepted by everyone in this Chamber, if they are serious about supporting our troops and supporting our Nation. This is where I say rhetoric meets reality.

My motion would instruct the conferees working on the bill authorizing actions by the Defense Department to allow our Nation's reservists and National Guard members and their families to be eligible to receive medical coverage from TRICARE on a cost-share basis. TRICARE, as my colleagues know, is the U.S. military's comprehensive health care plan.

Reservists have taken on a new and more active role since the 1991 Gulf War. Today, we see these brave young men and women risking their lives on a daily basis in Afghanistan, Iraq and elsewhere in this world. After September 11, the President signed an Ex-

ecutive Order authorizing the activation of reservists for up to 2 years of Active Duty, and up to 1 million reservists may be on Active Duty at any one time. Reservists have left their families, their friends and their jobs behind to serve our country, and they deserve health care for themselves and for their families.

I am offering this motion today because in our Nation we are still facing the same problems we did during the first Gulf War call-up, poor medical care for reservists as they get ready to be deployed. We are seeing many people sent to the front lines in Afghanistan and Iraq who may not always be at peak readiness due to a lack of access to medical care necessary to ensure maximum performance. We rely on these reservists so much now that it would be a mistake not to include them in TRICARE. Their health and their ability to fight should be of our utmost concern.

Our reservists should be provided with health care so they can remain in good health while they are not in service so that they are always prepared for mobilization in our global war on terrorism.

The Congressional Budget Office estimated the cost of this program to be \$460 million during the fiscal year 2004 and about \$7.2 billion over a 5-year period.

□ 1945

Some Republicans and the Bush administration say that this is too costly, and I just do not see how that argument holds water, as the Bush administration has sent Congress a supplemental bill for Iraq that proposes over \$20 billion in reconstruction and rebuilding efforts in Iraq alone, \$20 billion in reconstruction and rebuilding in Iraq alone.

Yes, U.S. tax dollars are rebuilding the irrigation system of Iraq, and this administration and this Republican Congress refuse to fund medical care for our Reserves and National Guard members. This \$460 million is a small price to pay to provide for our troops and to ensure their readiness when they are stateside. The U.S. will spend more to upgrade the housing of Iraqi citizens in the next month than we will on medical care for our Reserves and National Guard if we do not include this provision.

In comparison to the tax cuts for the richest 1 percent given by this administration and this Congress and the enormous cost of military operations and reconstruction in Iraq and Afghanistan, this should be, quite frankly, a no-brainer.

Some might say we need to do studies on this to see if it is feasible. We have done enough studies on this subject. Americans want action, not more studies. Studies are nice, but providing for readiness for our guard and reserve is a necessity. In fact, in 2002, a GAO report recommended Tri-Care assistance be provided during mobilizations

targeted to the needs of Reservists and their dependents. Another GAO report that dealt with Reservists being mobilized during the 1990-91 Persian Gulf War came to similar conclusions.

We cannot afford to do another study when 40 percent of our Reservists on active duty between the ages of 19 and 35, 40 percent of those people are uninsured. Tri-Care is only extended to active duty and not to Reservists, even though they are required to maintain the same standards.

Mr. Speaker, with the war on terrorism and continuing military operations in Iraq, with no valuable contribution from our European allies to this effort in sight, U.S. Reservists are clearly being called upon more and more. In fact, after September 8, it was announced that the deployment of Reservists in the combat theater is being extended from 6 months to 1 year. This is in addition to the fact that about half of the active duty Army is currently deployed abroad, up from 20 percent before 9/11.

Certainly our heavily stressed armed services and their families being required to make such extensive sacrifices deserve these health benefits. While many Reservists do have health benefits through their current employers, we cannot forget the 40 percent who do not. These are the patriots who make up the fabric of our communities and form the backbone of our defense forces. We cannot keep looking the other way when it comes to the Reservists of our armed services.

The administration already refuses to provide concurrent receipt for our veterans who are protecting our freedoms abroad. Until just this morning we were charging people who got injured on active duty for their food at U.S. military hospitals. Now we tell people, the local hardware store owner, the local Realtor, the stay-at-home mom raising a family, that we would love for them to serve as a Reservist, but we cannot offer them the same health care as active duty servicemen and servicewomen.

We continue to ask our Reservists to live up to their duties when we are not willing to provide them and their families with the proper health care that they need and that they deserve. We are creating a two-tiered military, with a separate set of benefits for Reservists than those offered active duty servicemembers. We cannot let this happen.

Join me in urging the conferees to accept the Senate provisions. Anything else, in my opinion, is a slap at our troops on the front line in our epic war against terrorism.

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

Mr. MCHUGH. Mr. Speaker, I yield myself such time as I may consume, and let me begin by expressing my appreciation to my friend and colleague, my fellow Representative, the gentleman from the great State of New York (Mr. CROWLEY), for his concern