

I urge my colleagues to support the Inslee motion to instruct to send a message to the DOE that it must learn to live within the rules and within the law.

□ 1515

Mr. INSLEE. Mr. Speaker, I yield such time as he may consume to the gentleman from Washington (Mr. BAIRD) who represents the third district, which is down river in the Columbia River from the Hanford site.

Mr. BAIRD. Mr. Speaker, I thank my friend from Washington for yielding me the time, and I thank my colleague also from the other side of the Cascade Mountain.

The reason I am concerned about this, since I represent Vancouver, Washington, we call it America's Vancouver, it is on the banks of the Columbia River, and it is down river from Hanford. For years, DOE has assured us that they had the cleanup under control. We have thousands of gallons of liquid waste in unlined single-wall tanks, and we were assured that they would not leak into the aquifer for hundreds of years. In fact, we have discovered already that there is nuclear material in that aquifer and that aquifer connects directly to the Columbia River.

The solution to our problems of disposing of radioactive waste is not to redefine them and say the problem's gone away because we came up with a new definition. That is essentially what the Department of Energy is asking to do, and I applaud my colleague for this motion. I thank the Chair of the committee for rejecting that.

So I am glad we are going to support this, but I would say this is troubling to me that the Department of Energy has even made this request because I think it raises questions about their good faith, that they believe that the solution to cleaning something up is to define that it is already clean and we do not have a problem. I urge the chairman of this committee to insist that such language not be allowed to exist in a final conference report and would urge my fellow colleagues, should that language somehow get in, to reject it strongly.

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

Just as a closing comment, Mr. Speaker, the one message we hope that comes out of today is that when we have 100 million gallons of material, that if we spread a coffee cup of it on this floor in the House, it would be a lethal dose for everyone here. This is material that our constituents on a bipartisan, bicoastal basis want to make sure gets cleaned up in reality, rather than just in rhetoric; and that is why I think this motion is very important.

I am very appreciative of my friend, the gentleman from Washington (Mr. HASTINGS), and his efforts to work with the Departments and the States to try to hammer out some solution to this. I know he has been personally involved

in trying to find that solution. I appreciate his efforts. We appreciate the gentleman from Texas (Mr. BARTON) in accepting this and moving this forward. He has also acted with honor and great wisdom, and I look forward to passage of this.

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

Mr. BARTON of Texas. Mr. Speaker, I yield myself such time as I may consume.

We will not oppose the motion to instruct the conferees, and we thank the gentleman for offering it and the individuals who spoke in favor of it.

Mr. BLUMENAUER. Mr. Speaker, I support Representative INSLEE's Motion to Instruct Conferees on H.R. 6, the Energy Bill. This motion instructs the conference committee to not add a provision that would allow the Department of Energy to reclassify high-level waste. I oppose the provision because it jeopardizes the health of citizens in Oregon, Washington, South Carolina, and Idaho. Of particular concern to me is radioactive waste stored in Hanford, WA, that has already contaminated ground water near the Columbia River. I believe this is one of the greatest environmental threats we face in the Pacific Northwest.

I also oppose the provision because it circumvents a legal decision made last July by a Federal district judge in Idaho. We should not allow defendants unhappy with a court decision to run to Congress for a quick fix solution. Furthermore, Congress needs to resolve controversial issues through careful consideration and debate. The proposed provision was in neither the House nor Senate bills, and was not subject to debate or vote. Most importantly, Congress did not hold hearings to hear from experts on both sides of this contentious issue.

This issue is too important to play political games. The Department of Energy should focus efforts on being a better partner with States to devise an efficient and effective solution that is agreeable to the people who live and work near the contaminated sites. All four States oppose the provision indicating that the department has not yet found a common ground solution.

Mr. BARTON of Texas. Mr. Speaker, I yield back the balance of our time.

The SPEAKER pro tempore (Mr. PUTNAM). The gentleman from Washington (Mr. INSLEE) is entitled to close. Does he wish to do so?

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

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 Washington (Mr. INSLEE).

The motion was agreed to.

A motion to reconsider was laid on the table.

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

Mr. BISHOP of New York. Mr. Speaker, I offer a motion to instruct.

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

The Clerk read as follows:

Mr. BISHOP of New York 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 to reject division B of the House Bill.

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

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

Mr. BISHOP of New York. Mr. Speaker, I yield myself such time as I may consume.

I rise today to offer a motion to instruct conferees on H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. In form, this motion instructs conferees to eliminate from the legislation the tax-free savings accounts for medical expenses. These accounts are estimated to cost the Federal Government \$174 billion over the next 10 years; and in my opinion, this funding would better serve seniors if it were used to close the enormous gap in coverage that exists in H.R. 1, as it currently is formulated, that leaves seniors without a dependable prescription drug plan.

Health savings security accounts are one of the many provisions in H.R. 1 that I find troubling. The health savings security accounts bill, like so many bills that this House has considered over the past few months, was brought to the floor in the middle of the night, in a last minute fashion, and was rammed through without debate. The bill passed largely along party lines and in the wee hours of the next morning was incorporated into the prescription drug bill through a rule. This Congress never had the opportunity to study such an enormous proposal.

Supporters of the tax-free savings accounts will tell my colleagues that these accounts are valuable tools to cover the uninsured; and clearly, we must prioritize providing health coverage to the greater number of the uninsured, especially since we learned recently that 2.4 million Americans joined the ranks of the now 43.6 million Americans who are uninsured in just the last year alone. However, these savings accounts will do very little to help the uninsured and are the wrong solution for several reasons.

The medical savings accounts are a bad idea because they will cost the States already struggling with deep financial difficulties \$20 to \$30 billion in revenues over the next 10 years and, as I indicated earlier, will cost the Federal Government \$174 billion over the next 10 years. The significant costs associated with these accounts will go towards providing benefits that I believe are merely illusory. These accounts are presented as a device that will help the uninsured. Yet 36 percent of the uninsured have incomes below the poverty

level so they pay little or no income tax. If their incomes are so low that they pay little in the way of income tax, then we cannot reasonably expect them to invest in medical savings accounts.

If the majority of the House feels that this \$174 billion is available to us and that we can afford to spend it, then in my opinion there is a much better way for us to invest it.

The prescription drug bill that passed the House has an alarming gap in coverage. Just when seniors reach the point when their drug costs become unbearable and they need help the most, the prescription drug bill leaves them to their own devices. Under the bill that passed, seniors will be forced to pay 100 percent of their drug costs from between \$2,000 and \$4,900 a year. This gap is so huge that 48 percent of Medicare beneficiaries, almost one-half of seniors, will fall into the gap. And as if this were not enough, seniors with drug costs over \$2,000 will continue to be required to pay their monthly premiums, even though they are receiving nothing in return.

I am increasingly discouraged that every time this Congress is faced with a choice of helping out those who need help the most or those who do not, we opt for those who need assistance the least. By eliminating the medical savings account provision from H.R. 1 and applying their \$174 billion in savings to close the gap in coverage, we will be doing the right thing by helping those that need it the most. This amount of money will significantly close the coverage gap and will give seniors whose prescription drugs costs are past \$2,000 a year great peace of mind. It is patently unfair to leave seniors to fend for themselves as their burden increases.

I urge my colleagues to support this motion and to do the right thing by our seniors by making this drug benefit more reliable. Let us send a strong message in support of seniors by giving them a prescription drug benefit with no gap in coverage.

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

Mr. MCCRERY. Mr. Speaker, might I inquire of the gentleman from New York (Mr. BISHOP) if he has additional speakers.

Mr. BISHOP of New York. I have about eight additional speakers.

Mr. MCCRERY. Mr. Speaker, as far as I know, I am the only speaker on our side. So I reserve the balance of my time until such time as the gentleman from New York (Mr. BISHOP) has arrived at his last speaker, and I will deliver my remarks at that time.

Mr. BISHOP of New York. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. SANDLIN).

Mr. SANDLIN. Mr. Speaker, I thank my colleague for yielding me the time.

Mr. Speaker, we have an opportunity today. We have an opportunity to make prescription drugs both available and affordable to our Nation's seniors. We have an opportunity to slam the

door shut on the giant Republican-sponsored gap in coverage in their so-called prescription drug bill, aka the HMO Enrichment Act. We have an opportunity today to help people in need, not HMOs in want.

How do we do that? We must close the gap in coverage in prescription drugs that has been invented and advanced by our friends on the other side of the aisle, and we can do that by supporting this instruction.

Mr. Speaker, as my colleagues know, the Republican drug plan provides absolutely no prescription drug coverage at all to our Nation's seniors between the amounts of \$2,000 and \$5,000; but even though they are receiving absolutely no coverage, they are required to pay a premium each and every month. Who wrote that provision, the HMOs? They expect to get paid a monthly premium every month like clockwork and provide absolutely no benefits to the seniors. That is outrageous, and how, oh, how, Mr. Speaker, can our Republican friends support such an outrageous position and favor the wealthy HMOs over our worthy seniors? How can they take that position?

Mr. Speaker, some on the other side of the aisle say we cannot afford to make prescription drugs available to seniors. It is not that we cannot afford it. Let us be honest. It is that they do not want to do that because, Mr. Speaker, apparently we can afford huge tax cuts to the top 1 percent of American wage earners, but we cannot afford a prescription drug coverage. Apparently, we can afford to allocate \$174 billion in tax cuts through the inclusion of HSAs, but we cannot afford prescription drug coverage.

Understand, Mr. Speaker, there is absolutely no requirement that the HSAs pass on savings to the employees. In fact, it is likely that employers will further burden American families by increasing deductibles and shifting costs to the employees; and understand, HSAs will not reduce the record number of uninsured in this country, and HSAs will not make prescription drugs more available for American seniors. It does none of that. In fact, just the opposite is true.

While HSAs will help almost no one in America, if we use those funds, that \$174 billion with a B, we could help address the prescription drug needs for everyone in America.

Let us keep our priorities straight in this Congress. Let us do something to benefit all Americans, not just the wealthy. Please join me and America's seniors in supporting this motion to instruct by my fine colleague. We need prescription drugs for all, not just a tax shelter, Mr. Speaker, for the few.

Mr. BISHOP of New York. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from North Dakota (Mr. POMEROY).

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

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

Let us take a look at the fiscal format of this country as we begin the debate on this measure this afternoon. We have seen revenue reestimate after revenue reestimate, all to the growing despair of those of us who care about running this country on a balanced budget, just like America's families run their financial affairs.

We are now looking at an annual deficit in excess of \$500 billion. I know the people I represent in North Dakota are really struggling with this request of the President to send \$87 billion to Iraq because they know that when we are \$500 billion in debt for this year, that this \$87 billion to Iraq is all borrowed money. That all falls on the heads of our children. It is important, I think, with that being the financial framework of our country, as we talk about this debate, that we look closely at what has happened to the staggering escalation in costs to this MSA, medical savings account, provision.

I am a member of the Committee on Ways and Means that considered this legislation. The initial proposal was scored by the Congressional Budget Office at \$14.3 billion over 10 years. I will submit this score from the Congressional Budget Office as part of the RECORD in this debate.

When it came before the committee, of course, we had seen the effect of special interests. This had been stretched. It had been inflated. It had grown, and this tax cut at that point in time, the MSA tax cut for the affluent, at that point became a \$71.5 billion bill. Because this country was in the red, I opposed this measure in committee. We had not seen anything yet in terms of the ultimate cost of the provision addressed by the gentleman's motion because the very next day there was a rewrite, not one that was accomplished in light of day, in committee of jurisdiction, where we could at least talk about the policy rationale for the further expansion of medical savings accounts; but when this measure came to the floor, many of us were astounded to see that a measure that had been passed out of committee costing \$71 billion over 10 years was now slated to cost \$174 billion over 10 years.

□ 1530

Somehow, overnight, \$100 billion in tax loopholes had been added to this measure. No hearing, no discussion, no committee vote.

So as my friends in North Dakota scratch their heads about the \$87 billion Iraq request of the President, they should know that is not the only thing to scratch your head about in Washington: \$100 billion added to this MSA tax loophole from committee action to the time of the floor. In contrast to that \$87 billion to Iraq, this is going to lose the Treasury \$173 billion.

Now, when we look at a \$173 billion hit to the revenue of this country, we

ought to think, well, can we afford it? Well, with a \$500 billion debt already, I do not think we can afford it. This will be paid for by further driving up the debt of our country. It will be ultimately borne by our children and grandchildren as we leave to them a country so swimming in red ink that it will be hard to figure out how they ever get back to a balanced budget.

Those days of surplus seem so long ago. And the reason we have gone down this terribly steep slope into these in-

credibly deep deficits is the very shenanigans we see before us. A bill that was \$14 billion in cost when it came to the committee came out of committee inflated and stretched to \$71 billion. And by the time it came to the floor, a further rewrite, not even in front of the public, not even in front of the committee of jurisdiction, not even with any discussion about the policy underlying the changes, and another \$100 billion in tax loopholes is offered, so that now \$173 billion in revenue is lost.

There is an awful lot that can be done with \$103 billion.

As a former State insurance commissioner, I can tell my colleagues that spending this kind of money on medical savings accounts is a very poor investment. Pass this motion, strip this tax windfall out of this provision.

Mr. Speaker, I submit for the RECORD the estimates of the CBO referred to earlier in my remarks:

ESTIMATED REVENUE EFFECTS OF H.R. 2596, THE "HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003," SCHEDULED FOR CONSIDERATION BY THE HOUSE OF REPRESENTATIVES ON JUNE 26, 2003

[Joint Committee on Taxation, 6-26-03, JCX-65-03; fiscal years 2004-13; in millions of dollars]

Provision	Effective	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-08	2004-13
Health Savings Security Accounts and Health Savings Accounts:													
1. Health savings accounts	tyba 12/31/03	-146	-433	-484	-541	-586	-633	-676	-700	-707	-752	-2,190	-5,658
2. Health savings security accounts	tyba 12/31/03	-628	-4,665	-7,853	-11,155	-14,500	-17,666	-21,041	-24,542	-29,232	-32,165	-38,802	-163,448
Total of Health Savings Security Accounts and Health Savings Accounts		-774	-5,098	-8,337	-11,696	-15,086	-18,299	-21,717	-25,242	-29,939	-32,917	-40,992	-169,106
Disposition of Unused Health Benefits in Cafeteria Plans and Flexible Spending Arrangements													
Exception to Information Reporting Requirements Related to Certain Health Arrangements	typba 12/31/03	-361	-627	-767	-867	-919	-957	-992	-1,023	-1,055	-1,094	-3,541	-8,662
Interactions Among Health Provisions	pma 12/31/02	-23	-24	-24	-25	-26	-27	-27	-28	-29	-30	-122	-263
		32	146	236	331	418	503	585	653	706	784	1,162	4,392
Net Total		-1,126	-5,603	-8,892	-12,258	-15,614	-18,780	-22,151	-25,640	-30,317	-33,258	-43,493	-173,639

Note: Details may not add to totals due to rounding. Legend for "Effective" column: pma = payments made after; tyba = taxable years beginning after.

ESTIMATED REVENUE EFFECTS OF A CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2351, THE "HEALTH SAVINGS ACCOUNT AVAILABILITY ACT," SCHEDULED FOR MARKUP BY THE COMMITTEE ON WAYS AND MEANS ON JUNE 19, 2003

[Joint Committee on Taxation, 6-18-03, JCX-64-03; fiscal years 2004-2013, in millions of dollars]

Provision	Effective	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-08	2004-13
1. Health Savings Accounts	tyba 12/31/03	-231	-1,785	-3,410	-4,876	-6,371	-7,503	-8,321	-9,271	-10,171	-10,668	-16,673	-62,607
2. Disposition of Unused Health Benefits in Cafeteria Plans and Flexible Spending Arrangements	tyba 12/31/03	-361	-627	-767	-867	-919	-957	-992	-1,023	-1,055	-1,094	-3,542	-8,664
3. Exception to Information Reporting Requirements for Certain Health Arrangements	pma 12/31/02	-23	-24	-24	-25	-26	-27	-27	-28	-29	-30	-122	-263
Net total		-615	-2,436	-4,201	-5,768	-7,316	-8,487	-9,340	-10,322	-11,255	-11,792	-20,337	-71,534

Note: Details may not add to totals due to rounding. Legend for "Effective" column: pma = payments made after; tyba = taxable years beginning after.

ESTIMATED REVENUE EFFECTS OF H.R. 2351, THE "HEALTH SAVINGS ACCOUNT AVAILABILITY ACT," SCHEDULED FOR MARKUP BY THE COMMITTEE ON WAYS AND MEANS ON JUNE 19, 2003

[Joint Committee on Taxation; #03-1 174 R, very preliminary, 6-18-03; fiscal years 2004-13; in millions of dollars]

Provision	Effective	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-08	2004-13
Health Savings Accounts:													
1. Income tax effect	tyba 12/31/03	-136	-405	-453	-507	-550	-594	-635	-655	-659	-702	-2,052	-5,598
2. FICA tax effect	tyba 12/31/03	-10	-28	-31	-34	-36	-39	-42	-44	-47	-50	-138	-360
Total of Health Savings Accounts		-146	-433	-484	-541	-586	-633	-676	-700	-707	-752	-2,190	-5,658
Disposition of Unused Health Benefits in Cafeteria Plans and Flexible Spending Arrangements:													
1. Income tax relief	tyba 12/31/03	-207	-361	-447	-509	-543	-568	-589	-607	-627	-654	-2,067	-5,113
2. FICA tax effect	tyba 12/31/03	-154	-265	-320	-358	-377	-390	-403	-416	-428	-440	-1,474	-3,551
Total of Disposition of Unused Health Benefits in Cafeteria Plans and Flexible Spending Arrangements		-361	-627	-767	-867	-919	-957	-992	-1,023	-1,055	-1,094	-3,542	-8,664
Net Total		-507	-1,060	-1,252	-1,408	-1,505	-1,590	-1,669	-1,723	-1,762	-1,846	-5,732	-14,322

Note: Details may not add to totals due to rounding. Legend for "Effective" column: tyba=taxable years beginning after.

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

I would just point out to the gentleman from North Dakota, Mr. Speaker, and to those listening to the debate, that the entirety of the cost of this bill, as noted by the gentleman from North Dakota, is accommodated by the budget that this House voted on earlier this year by a majority vote. Also, we should know that this bill, in its current form, at its current cost, as noted by the gentleman from North Dakota, passed this House with a bipartisan majority, with 15 Members of the minority supporting this bill in its current form.

So while it may be true that the bill changed from the time it was intro-

duced to the time it reached the floor, there is no one that was unaware of the cost when this was voted on by the Members of the House at large, and the amount is accommodated by the budget that we all agreed on earlier this year.

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

Mr. MCCRERY. I yield to the gentleman from North Dakota.

Mr. POMEROY. Mr. Speaker, I thank my friend for yielding to me, someone I respect deeply on the Committee on Ways and Means, the gentleman from Louisiana.

The gentleman notes that the money is fully accommodated for in the House budget. What I want to know is what

the relationship of the price tag is relative to the deficit. Now, as I understand it, this \$173 billion will deepen the deficit. Is that not the gentleman's understanding?

Mr. MCCRERY. Reclaiming my time, Mr. Speaker, as the gentleman well knows, the budget that was voted on by this House earlier this year, which takes care of all of the priorities of government which we have the duty and the obligation to do, did anticipate a deficit at the Federal level. So any spending that the gentleman wants to point out, whether it is for projects in his district or highways or any other thing, one could say that is going to drive us deeper into deficit.

But I think it is unfair for the gentleman to point out one item that we might pass and agree on and send to the President and say that is all going into the deficit. There are a great many other things we spend money on at the Federal level; and it would be fair to say, I suppose, that any one of those would be deficit spending.

Mr. POMEROY. Mr. Speaker, if the gentleman will continue to yield for one brief question, is the \$87 billion for Iraq requested by the President in the budget, or will that drive the deficit figure even deeper?

Mr. MCCRERY. Reclaiming my time once again, Mr. Speaker, as the gentleman knows, the \$87 billion is in the form of a supplemental request from the administration, and that is not covered by the budget that we passed earlier this year.

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

Mr. BISHOP of New York. Mr. Speaker, I yield 3 minutes to the gentleman from California (Ms. LINDA T. SANCHEZ).

Ms. LINDA T. SANCHEZ of California. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise in support of the Bishop motion to reject the use of \$174 billion for health savings accounts included in the Republican prescription drug bill.

On June 26, I, along with many of my colleagues, voted against the Health Savings and Affordability Act, H.R. 2596. It sounds like a great bill, but in reality these health savings accounts are a \$174 billion tax cut for the wealthy.

Republicans tell us these accounts will help those without health insurance, but in reality these people have incomes that are far too low to take advantage of the tax breaks in this bill. The truth is they do not have the additional \$2,000 to \$4,000 a year to put into these savings accounts.

While Americans are struggling daily, this Republican Congress is trying to give more tax cuts for the wealthy, and it is shameful to disguise it by putting it into the Medicare prescription drug bill.

At a time when our country is facing record deficits and so many seniors are struggling with rising drug costs, could \$174 billion not be better used? Could it not be used, as the gentleman from New York (Mr. BISHOP) has suggested, to significantly close the gap in coverage found in the current prescription drug bill?

Asking our seniors to pay 100 percent of their drug costs above \$2,000 until catastrophic coverage kicks in is simply unacceptable. This gap in coverage is the biggest problem in the prescription drug bill, and it would have a severe impact on millions of low-income Medicare beneficiaries.

That is why, instead of giving more tax cuts to the wealthy, we must help seniors cover their prescription drug costs. That is what seniors want, and that is what our seniors deserve. In

fact, according to a survey conducted by AARP, four out of five seniors did not want the Republican plan that ultimately passed this Congress.

Why did seniors oppose this plan? The answer is very simple: because under the current bill, 48 percent, nearly half of all seniors, would fall into the coverage gap and be forced to pay 100 percent of their drug costs. And that is in addition to the \$35-per-month premium, in addition to paying the first \$250 worth of drugs, and in addition to paying 20 percent of all their drug costs up to \$2,000 a year.

The coverage gap is unacceptable. It is no way to treat the seniors in our country. They expect more and they deserve more. Therefore, I urge my colleagues to support the Bishop motion and reject more tax cuts for the wealthy. Give our seniors the respect they deserve and the coverage that they need.

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

I would just point out, Mr. Speaker, that while we have had a couple of proponents of the motion to instruct mention that more money should be used for the prescription drug program, this motion to instruct does not direct any of the savings which would be gained from deleting division B of the Medicare bill to prescription drugs or for any other purpose. So while they may use conjecture to think about what they might use this money for, this motion to instruct has nothing to do with that.

Also, Mr. Speaker, I might point out that if this motion to instruct were to redirect that money to the prescription drug program, that would be in violation of the budget agreement that this House passed earlier this year.

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

Mr. BISHOP of New York. Mr. Speaker, I yield myself such time as I may consume.

I think the point of our contention that the monies saved by eliminating the Health Savings Security Act is that money that does not come into the Treasury is the same as money that comes in and is then spent. If the Treasury can afford to not take in an additional \$174 billion, our point is that the \$174 billion would be better spent in assisting people who really do need the assistance as opposed to providing comfort and benefit to those who really do not need the assistance.

Mr. Speaker, I yield 5 minutes to the gentleman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman from New York (Mr. BISHOP) for offering this motion and for standing up for senior citizens and persons with disabilities.

We just heard that a motion that would put the money into closing the huge gap in coverage that seniors citizens are going to face if this so-called Medicare prescription drug benefit passes, that it would be somehow a vio-

lation of the budget agreement, that, instead, we would rather have some sort of another tax shelter that takes another \$74 billion away in lost revenue is typical of the kind of proposals and the solution that have been offered.

Yes, the budget resolution says that we can give huge tax breaks to the wealthiest Americans; and now the way we are going to deal with the prescription drug plan is we are going to allow, again, people who have more money to be able to put it in a tax shelter so that they do not have to pay taxes on it.

What the Democrats are talking about, what the gentleman from New York is talking about is let us look at what the problem is. Senior citizens, persons with disabilities cannot afford the prescription drugs that they need. So if we have \$174 billion that we can use, why not just close that gap? That is the choice. The choice is between a \$174 billion tax shelter, unavailable to lower-income people, or using \$174 billion to try and redirect that so that Medicare beneficiaries get the coverage that they need. It is really as simple as that.

One thing that has not been noted in this \$174 billion tax shelter, that is the money lost to the Federal Government, is that it is also going to add about \$20 billion to \$30 billion in lost revenue to the States, according to the Center on Budget and Policy Priorities. Those lost revenues could further exacerbate the health care problem for low-income people. It might force States to make cutbacks in critical health programs, hurting, once again, the uninsured and the underinsured.

This kind of health savings account, this tax shelter, will also erode on-the-job coverage, because it will encourage employers to replace existing health coverage with high-deductible coverage. And it will especially hurt low-income families who cannot afford to pay those high deductibles, who cannot afford to contribute to a health savings account. What they are designed to do is to provide tax shelters and not to provide affordable coverage for the uninsured.

It is also very important to note, by the way, that the hole that exists in coverage for senior citizens and persons with disabilities for their prescription drugs does not exist in the health plan that is offered to Members of Congress. So if we want to make sure that President Bush is accurate when he tells senior citizens that he wants to give them what we have, what we have in our Federal employee plan, then we have to fill that gap. The hole in coverage right now is big enough so that 48 percent of seniors and persons with disabilities fall right in it.

We also know that nearly half of the Medicare beneficiaries live on less than \$18,000 a year. Many of them are low-income women living alone; and for them, a \$2,900 coverage gap is an insurmountable barrier to care.

□ 1545

That is what we have got right now. We will have senior citizens going to the pharmacy and saying I want the same medicine as I ordered last month, and the pharmacist will say, Mrs. Jones, that will cost you \$75.

What do you mean, I thought I had a prescription drug coverage?

Oh, it has run out for awhile now. You already have used it up. We will not pick it up again until you spend another \$2,900. Hello, people cannot afford that, nor can they afford a \$174 billion tax shelter that will provide help only to those who really can afford it, not to the millions and millions of seniors who cannot afford their prescription drugs. This is the choice that we have in front of us today. Let us do the right thing and support the Bishop motion to instruct.

Mr. BISHOP of New York. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I want to express my support for the Bishop motion for several reasons. First of all, as the previous speaker mentioned, the biggest problem with the Republican so-called drug benefit, because I do not think it is that at all, is that it is not generous enough. This is a voluntary program. If seniors feel they have to pay more out-of-pocket than they actually are going to gain by paying a premium for this drug benefit, they are not going to opt for it, and it is going to be meaningless. I think that is the problem with the House Republican bill. Even the bill that the other body passed, although better, has the same problem. The benefit is not generous enough, not meaningful enough for the average senior citizen to want it.

If we look at the gap in coverage, the so-called doughnut hole, the House Republican bill leaves beneficiaries 100 percent financially liable for all prescription drug costs between \$2,000 and \$4,900 in drug spending. So they are going to get some help, I think rather meaningless help, up to \$2,000, and then there is the catastrophic above the \$4,900; but in between, they are paying 100 percent of the costs. This leaves beneficiaries with a gap of \$2,900 where they still must pay premiums, but get absolutely no coverage for their plan.

So they are going to be paying so much a month under the House Republican plan, but after \$2,000, they have to pay 100 percent even though they are paying a premium. If they figure out what it is going to cost them out-of-pocket, as opposed to what they are getting, they will not even opt for the drug benefit because it will not be worth its value.

The Bishop motion says rather than leave this gaping doughnut hole, why not eliminate the health savings accounts, which is a totally meaningless proposal which just helps some rich people and use the money that the House Republicans allocate from that, \$174 billion over 10 years, to try to fill in at least part of the gap for the

doughnut hole so that seniors get something for their value and the drug benefit has some meaning.

According to the Joint Committee on Taxation, the health savings accounts that are included, this bogus proposal included in the House Republican bill, costs \$174 billion over 10 years. The health savings accounts provision will undercut employer-provided health care coverage. The benefits are available only if individuals are covered by high-deductible plans, in other words, plans providing no coverage for at least the first thousand dollars of medical expenses. A deductible of that size is approximately double the deductible of most employer plans. So what does it mean?

The provision will encourage employers to reduce coverage for workers and their families by increasing deductibles and shifting even more costs onto employees. The resulting cost savings will be enjoyed by the employer because there is no requirement that those savings be passed onto the employee.

For many American families, the tax benefits are completely worthless. The only thing they would receive from the health savings account provision is reduced health care coverage.

Most American families will not be able to take advantage of the tax shelter in these provisions because they do not have \$4,000 per year in additional savings. The health savings account provisions are designed to benefit employers and upper-income management, not rank-and-file employees.

Mr. Speaker, I just want to be clear, the serious limitations of this prescription drug benefit really need to be resolved so there is some benefit. I am just trying to make it perfectly clear. We have a lousy benefit with this huge, gaping doughnut hole. It needs to be filled up in some way so the benefit has some meaning, and the best way to do it is to get rid of this huge boondoggle, \$174 billion over 10 years from the health savings accounts, that is not going to help anybody. It is probably going to reduce employer coverage.

For the life of me, I cannot understand, of all of the motions that we have had on this issue, of all of the motions to instruct, this is the easiest for those on the other side to buy because they know when they go home and they talk to their constituents at home, a lot of them are concerned that the coverage in the House bill is meaningless, and they talk about the doughnut hole. If you have a forum, this is what the seniors talk about. Why not take away this lousy provision, the health savings account, which basically is not helping anybody, and use it to make a more generous benefit that maybe in conference, we could convince people on both sides, both in the Senate and the House, to adopt this as part of a conference report and have a meaningful drug benefit.

I would urge my colleagues to support the Bishop motion. I think it makes a lot of sense, and it should be passed on a bipartisan basis.

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

Mr. Speaker, I have heard several speakers today on the floor say that this is a tax loophole for the wealthy; it is just a way for the wealthy to be able to set aside tax free money because these high-deductible plans are not of use to anybody but the wealthy.

The high-deductible portion of this bill is the health savings account provision. The health savings account provision only accounts, according to the Joint Tax Committee, for \$5.5 billion of \$173.5 billion tax expenditure proposed by this bill. So it is not the high-deductible HSA, the health savings account, which has been alluded to here today, which accounts for the vast majority of costs under this bill. It is instead the health savings security accounts which eligibility for begins to phase out at \$75,000 of income for an individual. I hardly think anyone would call an individual making up to \$75,000 a year wealthy, able to take advantage of huge tax loopholes. I wanted to set the record straight on that.

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

Mr. BISHOP of New York. Mr. Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman for yielding me this time, and appreciate the good work the gentleman has done on health care in this body.

Mr. Speaker, I rise in support of the Bishop motion. The health savings security account provisions of H.R. 1 are misguided, they are misplaced; and, frankly, they are misnamed, misnamed because health savings accounts do not promote health security, they actually undercut health security. HSAs coupled with high-deductible insurance are a magnet for healthier and better-off individuals, ones who can use the tax break and are not put off by the \$1,000 deductible.

When the healthiest individuals leave existing insurance pools to buy high-deductible coverage, premium costs go up for everyone else. It is simple logic. Logic tells us that. So do studies by RAND, by the Urban Institute, and the American Academy of Actuaries. High-deductible health insurance discourages utilization of cost-saving preventive and routine care. It simply does not make sense to promote this type of coverage.

Do we really want to spend \$174 billion to inflate the cost of employer-sponsored health insurance and encourage the purchase of outdated, counterintuitive high-deductible health insurance?

The HSA provisions are misguided because the Census Bureau just reported now, since President Bush has taken office, almost 3 million more uninsured people in this country, partly connected to the fact that we have lost 3½ million jobs in the United States

since 2001. But most uninsured individuals will not benefit from the tax preferences built in the HSAs, so this proposal not only will not, but it simply cannot, make a dent in the large pool of uninsured. They are not a serious solution. We should not waste money on them.

These provisions are misplaced because this is a prescription drug coverage bill, not a health insurance coverage bill. If our goal is indeed to expand access to health insurance, then the conferees should be debating the best way to expand access to health insurance, and they are not doing that.

So do we want to get one thing right, or do we want to get two things wrong? Let us get the prescription drug coverage in this bill right, as the Bishop motion does. The drug coverage contained in this bill is woefully inadequate. Seniors with \$5,000 in drug expenses under the Republican plan would pay \$4,000 out of pocket. Five thousand dollars worth of drug expenses, and the government will only pay \$1,000; hardly insurance. The bill's coverage gap forces beneficiaries to pay 100 percent of their costs after the first \$2,000 of drugs have been purchased. The coverage does not begin again until drug spending reaches \$4,000. That is not really insurance. It makes you wonder if Republicans really think it is a good idea to penalize people for being sick. This huge hole in the coverage, if you are spending between 2 and \$4,000, you get no coverage on your drug costs. This motion, the Bishop motion, takes \$174 billion allocated for health savings accounts and devotes it to beefing up the prescription drug coverage. The additional funding helps eliminate the hole in that coverage. The Bishop motion makes sense.

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

I will point out once again that the motion to instruct before the House today does not in any way devote any funding to the prescription drug benefit. It merely deletes division B from H.R. 1. It does not supplement in any way, by any amount of money, the Medicare prescription drug benefit.

Also, Mr. Speaker, I would like to point out that I am familiar with the RAND study, it is probably the same RAND study cited by the last speaker which showed that yes, when people are spending their own money for health care, there is a reduction in the utilization of health care services. But if Members read on in that same study, it says that there was no significant decline in health outcomes as a result of that. I would submit as we go forward with the baby-boom generation about to retire, we should be looking at the effectiveness of health care expenditures and health care outcomes, and not how much money we can spend on how many health care procedures.

Mr. Speaker, in closing, we have had a good discussion today, I think, about some of the attributes of the health

savings accounts and health savings security accounts, and I am not going to give the big long speech which I have prepared here, I will submit that for the RECORD, and I also want to submit for the RECORD a recent article from the New York Times which talks about utilization of services in the health care system.

There has been a lot of talk today about wealthy people and low-income people and access to health care and health insurance and employer-provided health insurance.

Mr. Speaker, the whole idea behind health savings accounts and allowing employers to contribute on behalf of employees to health savings accounts, the whole idea of allowing employees to roll over \$500 a year from their flexible spending accounts into a health savings account or health savings security account is to get people coverage for health care. We have too many people in this country today who are either uninsured or underinsured. This bill, which passed the House, is designed to allow some of those people to get insurance.

I am not sure that the Members who spoke today have focused on the advantages of this bill. I think they are trying to find some way to get some money to put into prescription drugs which would not be allowable under the budget agreement that we have.

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But this bill before us that is the subject of the motion to instruct today is designed to get more people in this country insurance.

Yes, they could opt for high-deductible insurance. We think that is a good thing. At least they would have some insurance. By having a high-deductible policy for minor medical expenses, they would be spending their own money. And, yes, as the RAND study shows, they would be more prudent with their health care choices when they are spending their own money. That could help get overall health care costs down. It certainly could help inject into the health care system some market forces that are not there presently.

Mr. Speaker, I think, unfortunately, this motion to instruct is ill-advised. It is not designed to supplement the prescription drug program. It is designed to kill a very worthwhile tax incentive to encourage people in this country to get health insurance, to insure their families for health care expenses, and even if they are lucky enough to be basically healthy for most of their lives, to be able to use their health savings accounts and health security savings accounts to provide long-term care in their old age if they should need it. This is a very good proposal.

Mr. Speaker, the Motion before us is an interesting one. Generally made by a member of the minority party, Motions to Instruct allow this Chamber to go on record with respect to one aspect of a measure pending in conference.

These motions generally tackle a specific piece of a bill and allow the moving party to encourage the House to recede to a Senate-passed provision or to force the House to take a position on a provision or provisions which were not subject to an individual recorded vote during House debate.

That is not the case here. The House has already voted, overwhelmingly, against the position being advocated by my colleague from New York.

While the Motion before us is a new one, the issue is not. The Motion asks the conferees to reject Division B of the House-passed Medicare bill, which, as my colleague from New York has noted, relates to the creation of tax-favored savings accounts to meet current and future health care needs.

Before becoming Division B of H.R. 1, the text in question was a stand-alone bill, H.R. 2596. On June 26 of this year, the House voted to pass that measure by a vote of 237 to 191. I should add that the vote was bipartisan, with 15 Members of the minority supporting the provision.

Under the terms of debate for the bill, as set by the Committee on Rules, H.R. 2596 was appended onto H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003 as Division B.

Mr. Speaker, I have provided this detailed legislative history so that we can all understand that the House is already on record on the issue presented by the Motion to Instruct. Before casting their votes on this Motion, I hope my colleagues will review their vote on the identical issue which occurred on June 26.

Having discussed the legislative history of this provision, let me turn to the substance, which is not less distinguished.

This week, the Census Bureau reported what we all know to be true. There are far too many Americans without health insurance. The economic slow-down, from which we are only now starting to recover, left too many without jobs and has caused some workers to lose employer-sponsored health insurance.

That problem demands bold and innovative thinking. I have long believed that the employer-based system for health insurance, the product of historical happenstance, must be radically restructured if we are to provide affordable health insurance for all Americans. I have worked across party lines to explore this issue and hope those efforts will someday lead to fruition.

Part of the solution lies in taking steps which increase personal responsibility. That is why the provisions creating HSAs and HSSAs are so important.

Mr. Speaker, I will insert in the record an article which ran in the New York Times on September 13, 2003 entitled "Patients in Florida Lining Up for all That Medicare Covers".

The article outlines how some seniors, shielded from the true cost of health care services by Medicare and supplemental insurance, have turned visits to doctors from a dreaded necessity into a focal point of their social schedule.

The conclusion, frankly, is not a shocking one. I think we all know that people tend to consume more of things they perceive to be free. To the extent health insurance features low deductibles and minimal cost-sharing, enrollees are more likely to consume health care goods and services which they otherwise might not. This lack of personal responsibility

is at the root of many of our health care cost problems.

Division B of H.R. 1 takes concrete steps to ensure that health care consumers have more responsibility and more influence, in our healthcare system. Thought there are important differences, HSA policies are only available to those individuals who buy higher deductible health insurance. HSSAs will be available to those with more traditional health plans, but they may also be established by those who have no health plan at all, are therefore uninsured and who, I suppose, could be thought of as having an infinite deductible.

By encouraging Americans to shift to higher-deductible health insurance, these accounts address a fundamental problem in health care today—the phenomenon of first-dollar coverage paid for by third-parties.

In his comments, my friend from New York indicated that these accounts will be used by the wealthy as a way to save money tax-free. About that I have several comments.

First, in reviewing this bill, the Joint Tax Committee did estimate that enactment would result in a revenue loss to the Government of about \$173 billion over the next decade. The vast majority of that loss came from individuals establishing HSSA accounts. Yet individuals can make tax-deductible contributions to HSSAs only if their incomes are below certain thresholds. Mr. Speaker, HSSA account holders are not the idle rich, looking for a tax shelter. They are the families in this country trying to get by and maybe get ahead a little.

Allowing them to set aside some money on a tax-free basis for health care hardly seems like a tax-shelter. In fact, if the funds in an HSSA are not used for health care, the distribution is generally taxed as ordinary income and subject to an additional 15 percent tax. The 15 percent penalty does not apply if the account holder becomes disabled or withdraws the funds after reaching age 65.

It is true that account balances remaining upon death are included in the decedent's estate. And, if the estate tax repeal is made permanent—as a vast majority of this Chamber supports—it is possible that some of these funds set aside for health care might be used for other purposes.

But that fear is not in my estimation a good reason to reject an improvement to the tax code which will increase personal responsibility and whose benefits flow predominantly to those who otherwise will have the most difficulty meeting their health care needs as they age.

Second, Mr. Speaker, a population today having real difficulty with high health care costs are those who are retired or laid off but not yet eligible for Medicare. Caught in this gap are millions of Americans between the ages of 55 and 65. As account balances in HSSAs may be used to purchase individual health insurance, these accounts could be a real helping hand to those too young for Medicare but not eligible for other employer-sponsored coverage.

Third, if we really want to tackle the issue of "tax fairness," it is not appropriate to look at the creation of HSAs and HSSAs in isolation. Let's look at all of the tax subsidies, both hidden and explicit in the tax code and how they operate today.

Consider the fact that in 1999, the Federal Government "spent" approximately \$100 billion in a hidden tax subsidy for health care,

the exclusion from income, and therefore taxes, of the value of employer-sponsored health care. If that exclusion were not in place, meaning employees were taxed on the value of the health benefits provided as if it were ordinary compensation, the federal government would have collected an additional \$62 billion in income tax that year and \$34 billion in FICA contributions.

Those are large and abstract numbers. Let's break them down and see what they mean to American families. According to the Lewin Group, the tax exclusion provided the average family with a subsidy of \$1,155 in 2000. But the benefits were not evenly divided. Families with incomes under \$15,000 averaged just \$79 in benefits, while families with incomes over \$100,000 received an average subsidy of more than \$2,600.

Mr. Speaker, those figures are both shocking and disappointing. Encouraging employers to provide bigger and more generous health plans is not the answer.

In addition to the odd distributional effects of the tax exclusion, there is ample evidence that the richest benefit packages are offered by employers with higher-income workers. A 1998 government survey found that only 42 percent of Americans under age 65 with incomes under 250 percent of poverty have insurance through an employer, compared to 83 percent of Americans with incomes above that level.

Part of the reason may be because businesses with low-wage workers are less likely to offer health insurance. A Kaiser Family Foundation report in 2000 found that two-thirds of small businesses offer coverage to their workers. But that number is cut in half for small businesses in which more than 35 percent of the workers make less than \$10 per hour.

Part of the reason may also be that when coverage is offered to lower-income workers, it is generally offered on less favorable terms. A Moran Company study in 2000 found the average employees' monthly premium for family coverage was \$130 for workers earning less than \$7, while the cost for employees earning more than \$15 per hour was just \$84.

Mr. Speaker, these are depressing statistics. I stand ready to work with any of my colleagues in designing a system which more rationally allocates scarce resources for health care.

In the meantime, however, we must recognize that the uninsured and lower-income families are at a severe disadvantage when it comes to health benefits. I would not stand here and tell you that allowing them to set up tax-favored HSSAs is going to solve all of the distributional problems I mentioned. But surely providing more Americans an opportunity to use pre-tax dollars for health care cannot be a bad thing.

I should also mention two other important provisions in Division B which merit their own discussion.

First, the bill would allow individuals with unused balances in Flexible Spending Accounts to roll-over up to \$500 each year. Even worse than insurance plans which make medical care appear free, FSAs have a use-it-or-lose-it feature. As a result, many account holders scramble at the end of each year to exhaust their accounts on marginally beneficial health care services. By allowing account holders to roll-over some unused funds, the provision re-

duces the very perverse current law incentive encouraging this over-consumption of health care.

Second, the provision contains a clarification of current law which will eliminate a burdensome requirement on FSA plans which use debit cards to make and track account-holders' health care spending.

In May, the Treasury Department and the Internal Revenue Service published a Revenue Ruling providing guidance on the use of debit and stored-value cards used to make payments under FSAs and health reimbursement accounts. Overall, the procedures will make it easier for millions of Americans to use stored-value cards to access the benefits of these accounts.

There is, however, an impediment to the expanded use of these Cards. The Revenue Ruling requires that employers and other plan sponsors issue Form 1099 reports to service providers who accept these Cards. There is little evidence that the requirement will affect the administration of the tax code, but the administrative and paperwork burdens will serve as an impediment to the use of these stored-value cards.

I was pleased that H.R. 2596 included a provision overriding the 1099 requirement. I have since written to Secretary Snow, urging him to issue a new Revenue Ruling removing the 1099 requirement.

Based on conversations with Treasury officials, I am hopeful that this can be addressed without action by the Congress but am concerned that passage of this Motion could signal Treasury that Congress does not care if the 1099 requirement is left in place.

Before concluding, Mr. Speaker, I do want to respond to concerns that the deficit is too large to justify a tax cut of this kind.

I, too, am troubled by the recent projections of significant deficits for the next several years. But, as a share of our national income, those deficits—and more importantly the debt as a percentage of our gross domestic product—remain manageable.

More importantly, to the extent HSAs and HSSAs allow Americans to accumulate funds to pay for health care and encourage them to consume medical services more prudently, we can stem the otherwise unchecked growth in medical inflation which is, in my estimation, the most serious cause of long-term upward pressure on our budget picture.

Finally, Mr. Speaker, let me express my concern about any Motions to Instruct the conferees on H.R. 1. As my colleagues are well aware, the issues surrounding the creation of a Medicare drug benefit are as numerous as they are complex. These discussions will only be brought to a successful conclusion if the conferees are able to creatively address the difference between the two bills.

By artificially seeking to tie the hands of the negotiators this motion makes it less likely, rather than more likely that the conferees will be able to strike the delicate balance necessary to produce a bill acceptable to each Chamber and the President. Accordingly, we should reject this Motion for fear it will make it less likely that a Medicare prescription drug benefit can be enacted this year.

Mr. Speaker, I urge my colleagues to affirm the vote this House took in June and to defeat the Motion to Instruct.

[From the New York Times, Sept. 13, 2003]
 PATIENTS IN FLORIDA LINING UP FOR ALL
 THAT MEDICARE COVERS
 (By Gina Kolata)

BOCA RATON, FLA.—It is lunchtime, and the door to Boca Urology's office is locked. But outside, patients are milling about, calling the office on their cellphones, hoping the receptionist will let them in. To say they are eager hardly does them justice.

"We never used to lock the door at lunch, but they came in an hour early," said Ellie Fertel, the office manager. "It's like they're waiting for a concert. Sometimes we forget to lock the door and they come in and sit in the dark."

Yet few have serious medical problems, let alone emergencies. "It's the culture," said Dr. Jeffrey I. Miller, one of four urologists in the practice.

Doctor visits have become a social activity in this place of palm trees and gated retirement communities. Many patients have 8, 10 or 12 specialists and visit one or more of them most days of the week. They bring their spouses and plan their days around their appointments, going out to eat or shopping while they are in the area. They know what they want; they choose specialists for every body part. And every visit, every procedure is covered by Medicare, the federal health insurance program for the elderly.

Boca Raton, researchers agree, is a case study of what happens when people are given free rein to have all the medical care they could imagine. It is also a cautionary tale, they say—timely as Medicare's fate is debated in Congress—for it demonstrates that what the program covers and does not cover, and how much or how little it pays, determines what goes on in a doctor's office and why it is so hard to control costs.

South Florida has all the ingredients for lavish use of medical services, health care researchers say, with its large population of affluent, educated older people and the doctors to accommodate them. As a result, Dr. Elliott Fisher, a health services researcher at Dartmouth Medical School, said, patients have more office visits, see more specialists and have more diagnostic tests than almost anywhere else in the country. Medicare spends more per person in South Florida than almost anywhere else—twice as much as in Minneapolis, for example.

But there is no apparent medical benefit, Dr. Fisher said, adding, "In our research, Medicare enrollees in high intensity regions have 2 to 5 percent higher mortality rates than similar patients in the more conservative regions of the country."

Doctors say that Medicare's policies are guiding medical practice, with many making calculated decisions about whom to treat and how to care for them based on what Medicare covers, and how much it pays.

"The bottom line is that the stuff that reimburses well is easier to get done," Dr. Carl Rosenkrantz, a Boca Raton radiologist, said.

Thomas A. Scully, administrator of the Centers for Medicare and Medicaid Services, said he knew the situation all too well.

"We have a system that does nothing to look at utilization," Mr. Scully said in a telephone interview. "If you send in a bill and you are legitimate, we pay it."

The effect shows up in the way doctors deal with office visits, for example. Medicare in Boca Raton pays \$52.46 for a routine visit, in which a doctor sees a patient with no new problem. That is not enough, doctors say; it costs about \$1,500 a day to run an office there, they explain. Payments in other states are different, adjusted for cost of living, but doctors say, and Mr. Scully agrees, that they are generally inadequate. Doctors who try to make a living seeing only Medi-

care patients for routine visits, he said, "have a very rough time."

Medicare bases its payments on a system in which each kind of service is assigned a "relative value," Mr. Scully said. To increase the payment for routine office visits and stay within its budget, Medicare would have to decrease the relative value of other services.

A committee of doctors meets each year to suggest relative values, he said, but "the most aggressive and active groups tend to be the specialists."

"Year after year," Mr. Scully went on, "the specialists come in and make a very strong argument for higher reimbursements. There's eventually a squeeze on the basic office visit."

In many areas of the country, private insurers pay more for office visits than Medicare does, so doctors can essentially subsidize their Medicare patients.

"If we just saw Medicare patients and didn't see anyone with regular insurance, we wouldn't be able to pay the bills," said Dr. James E. Kurtz, an internist at Chatham Crossing Medical Center in Pittsboro, N.C.

Elsewhere, many doctors are refusing to see Medicare patients. "Some counties in Washington have no doctors who take new Medicare patients," Dr. Douglas Paauw, a professor of medicine at the University of Washington, said.

Doctors in South Florida do not have a choice. Private insurers there pay the same as Medicare or less, and so many old people live in the area that if doctors want to practice, they must accept them. But how to make a living?

One way, Dr. Robert Colton, an internist in Boca Raton, said, is to see lots of patients, spending just a few minutes with each and referring complicated problems to specialists.

Dr. Colton did that for a while, seeing as many as 35 patients a day. A typical busy internist, he said, would see 20 patients a day. "I felt like a glorified triage nurse," he said.

"If you try to handle a complex problem, it slows you down," Dr. Colton said. "You have to sit down with the family, meet with the patients, talk to them. If you say you have coughing and you are short of breath and your knee hurts, I might have sent you to two different specialists."

The goal, Dr. Rosenkrantz said, is to move the patients on. "The worst thing than can happen is for someone to walk into your office and say, 'I have an interesting case for you.' Financially, you'd be dead."

Even seeing patients in the hospital can become an exercise in time management, Dr. Rosenkrantz said. "We have doctors who do rounds at 4 a.m."

A second driving force behind medical care in Boca Raton is the demands of patients. They want lots of tests and specialists, they refer themselves to specialists, they ask for and get far more medical attention from specialists than many doctors think is reasonable or advisable.

"This Medicare card is like a gold card that lets you go to any doctor you want," Dr. Colton said, "I see it every day. When there's no control on utilization, it's just the path of least resistance. If a patient says, 'My shoulder hurts, I want an M.R.I., I want to see a shoulder specialist,' the path of least resistance is to send them off. You have nothing to gain by refusing."

Patients here say they have mixed emotions. They complain about rushed primary care doctors but readily admit that they seek multiple specialists and multiple procedures.

The primary care doctors are often irritatingly busy, patients say. "In waiting rooms sometimes they are standing against

the wall," said Marvin Luxenberg, a retired lawyer who lives in nearby Boynton Beach. Then, he said, "when you get in to see the doctor, you get just three or four minutes of time."

Dr. Colton says he found a way to give his patients more time. He joined a "concierge" practice, in which patients pay an annual fee in addition to the normal charges for medical services. Dr. Colton's group, MDVIP, charges patients \$1,500 a year and limits the number of patients each doctor sees.

But not everyone wants to pay that kind of fee. Many patients just spend their time in specialists' offices. Each specialist handles a different aspect of their care, with no one coordinating it.

Specialists get no more than primary care doctors for an office visit, but they provide tests and procedures that demand higher Medicare reimbursements. Doctors say those payments allow them to stay in business, especially if they provide the procedures in their own office.

Medicare pays the doctor and the facility where a procedure is done. For a nuclear stress test, for example, the doctor gets about \$200 and the facility gets about \$1,200.

"Doctors have incorporated these tests as much as possible into their offices so they can gain from the facility fee," Dr. Thomas Bartzokis, an interventional cardiologist in Boca Raton, said. Patients say they have lots of specialists, and lots of tests. Asked how many doctors he saw, Leon Bloomberg, 83, a patient of Dr. Miller, thought for a minute and looked at his wife, Esther.

"Between us, we have 10 or 12," Mr. Bloomberg said, including a pain specialist and a neurologist for his neuropathy, a cardiologist for his heart condition, "a pulmonary man" for his asthma, a rheumatologist for his arthritis and Dr. Miller for his prostate. Mrs. Bloomberg has her own doctors, including ones for heart disease and for diabetes. "We have two to four or more doctors' appointment a week," Mr. Bloomberg said.

It is easy to find all these specialists, he said. "You get recommendation at the clubhouse, at the swimming pool. You go to a restaurant here and 9 times out of 10, before the meal is over, you hear people talking about a doctor or a medicine or a surgery." And of course there are the other patients in all those waiting rooms. Mr. Bloomberg even recommends specialists to his own doctors.

But some patients say they are frustrated by what they call a waste of resources. "The doctors are raping Medicare," said Louis Ziegler, a retired manufacturer of flight simulators who lives in Delray Beach.

Mr. Ziegler recalled going to a doctor for a chronic problem, a finger that sometimes freezes. All he wanted was a shot of cortisone. But he got more, much more: "I had diathermy. I had ultrasound. I had a paraffin message. I had \$600 worth of Medicare treatment to get my lousy \$35 shot of cortisone."

Dr. Colton, the internist here, is frustrated, too.

"The system is broken," he said. "I'm not being a mean ogre, but when you give something away for free, there is nothing to keep utilization down. And as the doctor, you have nothing to gain by denying them what they want."

Mr. Speaker, I yield such time as he may consume to the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means.

Mr. THOMAS. I thank the gentleman for yielding me this time.

Mr. Speaker, I take the floor because I was off doing other business but listening to testimony that has been presented on this floor; and if something

gets repeated often enough and loud enough, people may begin to think that it is true.

In depicting the proposal that has been offered for seniors and prescription drugs, much has been made of the fact that when you have limited dollar amounts and you want to write a program that benefits the greatest number of people, the logical way to write the program is to provide reasonable benefits so that most people who have small drug costs have a decent shared payment structure. In the House plan, that happens to be 80 percent government payment and, 20 percent individual. And for those who, through no fault of their own, have extremely high drug costs, above a certain point, 100 percent of those costs are assumed by the government, or the taxpayers. That is called typically a catastrophic plan.

The question is, how much would it cost to provide sliding coverage throughout an entire range?

Many drug programs are set up where they have a period at which the individual pays the full cost. It has been depicted over and over again and, most recently, just a few minutes ago, that this is a program we are trying to provide to seniors which we do not have as Members of Congress. That is flat-out not true.

If, in fact, Members of Congress can take their insurance from the Federal Employees Health Benefits Program, which is where we get it, if anyone would take the time, instead of preparing demagogic speeches for the floor of the House, and study the Federal Employees Health Benefits Program, they will find there are programs offered to Federal employees that have what is called, in a pejorative way, a doughnut hole. Why? Because it makes sense to build insurance plans at a dollar amount with a doughnut hole.

The program that we have built makes sense. Programs in the private sector do the same. Programs that are offered to Federal employees, including Members of Congress, do the same thing. This is not some unique concept that we have dreamed up. It is a common practice in insurance.

So I fully expect, if this is not done just for show, if someone really did not know, and if in fact they are now pleased to have the facts, I do not expect another Member to take the floor and say we ought to give to seniors what we give to Congress and other members of the Federal Government and that they don't have a doughnut, so we shouldn't have a doughnut for seniors. The fact of the matter is, the Federal Employees Health Benefits Program has plans that are actually chosen by Federal employees that have doughnuts. Why? Because it makes sense. It provides you the maximum minimum payment when your drug costs are low and it provides you the maximum coverage at the top end when your drug costs are high.

But remember what I said, if you are dealing with a fixed cost. The Congress

said you have \$400 billion to build a prescription drug program in a modernized Medicare. That is a fixed cost. For some people who do not believe the taxpayers' money should be accounted for or you should cater to groups so that you can give people whatever they want regardless of what it costs, I can understand why a sensible program, to give maximum benefits to the greatest number of people, would be a puzzle. But for people who live on budgets and for people who are cognizant of taxpayers' dollars, building a plan for a given amount that brings the maximum benefits to the greatest number of people makes all kinds of sense. That is why, even in the Federal Employees Health Benefits Program, they have insurance programs that have doughnuts.

I am quite sure now we will never hear another word about saying we are trying to give seniors something that the Federal employees do not have, because it is not true.

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

Let me thank the gentleman for his remarks that explain very well the rationale for what we think is an excellent prescription drug program that we constructed within the confines of the budget, the \$400 billion in the budget.

But, once again, Mr. Speaker, let me point out that the motion to instruct before us has nothing to do with the prescription drug program. It in no way relates to the prescription drug program. It does not allocate a dime of spending, extra spending, to the prescription drug program. All the motion to instruct before us today does is delete from H.R. 1 a very worthwhile tax incentive designed to get more people in this country health insurance coverage for themselves and their families.

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

Mr. BISHOP of New York. Mr. Speaker, I yield myself the balance of my time.

In closing, let me just say a few things. Chairman THOMAS just made reference to the fact, he talked about the difficulty associated with developing plans and writing legislation when there are limited dollar amounts available. Certainly he is right about that. But I think it is important that we recognize that one of the reasons that we have limited dollar amounts available for this and so many other benefits is that we have been on a tax-cutting frenzy in this Congress in the last several months.

We are now talking about the instant issue, the \$174 billion for health savings accounts; \$350 billion tax cut over 10 years that we approved in March. We all know that that number is probably an illusion. It is probably going to be closer to \$1 trillion over 10 years because we all know that the sunsets really are not going to happen. The estate tax, the permanent elimination of the estate tax of \$161 billion, and the,

let us say, the overreaction to fixing the child tax credit problem. We have put in place an \$82 billion solution to a \$9 billion problem.

These tax cuts have two things in common, in my view. One is that they disproportionately favor the well-to-do and second is that they will not do what they purport to do. The health savings accounts purport to help the uninsured become insured and be able to handle their health expenses. It is not going to happen because so many of the uninsured are those who cannot afford insurance and cannot afford these accounts under any circumstance. And the other tax cuts have been designed, we are told, to stimulate the economy and create jobs, yet we continue to lose jobs at an alarming rate in this country.

It seems to me that what we are doing is we are throwing solutions at problems without really knowing whether the solution will work or not.

In the case of the prescription drug package, we do in fact know that if we make the benefit more substantial we will be truly helping people in need and we will be providing a real solution to a real problem.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of this motion. The House Republican bill includes \$174 billion over 10 years for health savings accounts (HSAs). That money is desperately needed to fill the doughnut hole they put in the seniors' prescription drug coverage.

Not only are HSAs a waste of \$174 billion over 10 years, they will also undercut the system of employer provided health care coverage that we have today. The benefits of HSAs are available only if individuals are covered by high deductible plans, i.e., plans providing no coverage for at least the first \$1,000 of medical expenses. A deductible of that size is approximately double the deductible of most employer plans.

Therefore, the provisions will encourage employers to reduce coverage for workers and their families by increasing deductibles, and shifting even more costs on to employees. The resulting cost savings will be enjoyed by the employer because there is no requirement that those savings be passed on to the employee.

For many low to moderate income American families, the tax benefits are worthless. The only thing they would receive from the health savings account provisions is reduced health care coverage. The HSA provisions are designed to benefit employers and upper-income management, not the hard working regular employees who are being crushed by today's economy.

Because of gross financial mismanagement and misplaced priorities, we have only \$400 billion to spend over the next 10 years on getting seniors and the disabled the prescription drugs they need to live. As we look at the skimpy benefit package the Republicans have put together we have to wonder how we can still afford to spend 100s of billions of dollars on pre-emptive war. But, that is the box they have put us in, and that is what we need to deal with. So, if we only have \$400 billion, it is irresponsible to spend \$174 billion of it on a tax shelter that will erode the health insurance coverage of those who really need it.

This money would be much better spent improving the drug benefit, getting coverage to the growing number of uninsured, or bringing down our deficit. The Republican bill leaves nearly half of all seniors with no coverage for part of the year, even while they continue to pay premiums. Vote "yes" on the Bishop motion to fill that gap in coverage.

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of the motion to instruct conferees on H.R. 1 offered by my colleague from New York, Mr. BISHOP, and I commend him for offering it.

Medicare, which Republicans fought against at its inception and continue to attempt to undermine today, is an entitlement. It is available equally to everyone over the age of 65 who has paid into the system, and provides the security and peace of mind individuals need and deserve when they are disabled, or have reached retirement.

This motion to instruct the Conference committee would strike the new savings accounts portion of the House bill, and use the \$174 million instead to close the gaping hole that 48 percent of Medicare beneficiaries would fall through.

In addition to making good common sense, it also makes good on our promise to seniors to give them a prescription drug benefit. We did not say a half a benefit or three quarters of a benefit, or a ring of a benefit, but a comprehensive benefit.

Additionally, I would further instruct the conferees to ensure that no group, regardless of income, should be left out or be made to pay for inclusion in this program. To do otherwise would further undermine Medicare. Low-income patients, who depend on Medicare's assurance of access to healthcare, must not be kicked off the program and on to Medicaid, especially since this benefit is not fully extended to the American citizens living in the territories. To do this would renege on the basic promise of Medicare to all of its eligible seniors and disabled.

In reaching an agreement, I would call the attention of the conferees to the fee-for-service chronic care management provisions especially as included in the House provisions. This is a good provision that would do much to cut the skyrocketing cost of health care to those most at risk for either acute or chronic institutionalization.

Finally I would point out to the conferees and all of my colleagues, that this benefit is not scheduled to take effect until January of 2006. Rather than kill or damage an important safety net program in this time of great uncertainty, let's wait and take the time to do it right.

Although, I fundamentally disagree with the premise and direction of both the House and Senate prescription drug bills, it should be noted that the Republican prescription drug plan does nothing to expand prescription drugs to the million of seniors that are in dire need of such help.

Both bills have a gap in coverage for Medicare beneficiaries, but the Senate bill, unlike the House bill, has no gap in coverage for low-income seniors. Under the House bill, low-income individuals receive no assistance in meeting their drug costs over \$2,000 until they have spent \$3,500 out of their own pockets on prescription drugs; 41 percent of total income for someone at the federal poverty level.

The House bill provides virtually no low-income assistance for those with incomes over

135 percent of poverty (\$12,123 for an individual). The Senate provides substantially assistance for individuals with incomes up to 160 percent of poverty.

The House bill includes an assets test that will prevent many low-income people from receiving assistance. The Senate bill allows low-income people who do not meet the assets test to qualify for the same assistance available to those with incomes between 135 and 160 percent of poverty.

No prescription drug program that does not provide comprehensive, low-cost prescription drug coverage to low income senior citizens can meet the needs of our constituents. The special benefits provided the low income under the Senate bill effectively addresses our concerns. However, the principle of universality and nondiscrimination that is central to the Medicare program demands that basic drug coverage be provided through Medicare, as specified in the House bill.

The Senate low-income assistance provisions are far superior to the House provisions, and these assistance provisions are of particular importance to the Nation's African American communities. There are 2,853,000 African American Medicare beneficiaries over age 65. Of these, almost 22 percent or 626,000 individuals are below 100 percent of the Federal Poverty Level (\$8,980 for an individual, \$12,120 for a couple). Another twenty percent live on incomes between 100 percent and 150 percent of poverty. This compares to a total of 9 percent of Caucasian senior beneficiaries below 100 percent of poverty and another 14 percent of Whites living on incomes between 100 percent and 150 percent of poverty.

As you can see, nearly twice as many African-American Medicare beneficiaries are living in poverty compared to the total Medicare population—and that means the pharmaceutical drug needs of this population are not being met.

For example, low-income Medicare beneficiaries without prescription drug insurance are able to fill only about 20 prescriptions per year, compared to 32 prescriptions per year for those with insurance. By providing better assistance to the low-income, the Senate bill will help fill this 'prescription gap.'

The differences in the low-income provisions of the House and Senate are clear:

House provides deductible and co-pay help only up to 135 percent of poverty (\$12,123 per year for an individual);

Senate provides meaningful help up to 160 percent (\$14,368 for an individual);

House imposes an asset test as a condition of getting low-income assistance. The asset test means that a low-income person is ineligible for assistance if they own any disposable assets (like U.S. savings bonds) of more than \$6,000 for an individual or \$9,000 for a couple. This test disqualifies several million low-income beneficiaries from getting any special assistance;

The Senate permits even those who do not meet the asset test to get special assistance in meeting the costs of co-pays and deductibles;

The House does not provide any assistance whatsoever to the low-income when they have \$2,000 to \$4,900 worth of prescription drug expenses (when they are in the so-called donut hole);

The Senate provides substantial help in meeting 80 percent to 95 percent (depending

on exactly how low-income an individual is) of the costs of the "donut."

When you combine all these provisions, the impact is dramatic. For example, if a Medicare beneficiary is living on \$12,123 a year (135 percent of poverty), and his or her doctor has prescribed \$3000 worth of medicines, in the House bill, the beneficiary will owe \$1,114 out of pocket (assuming they meet the asset test and have almost no liquid assets). Under the Senate bill, the person will only owe \$150. Under this example, an individual who obviously had medical problems and has other out-of-pocket expenses for doctors, tests, etc., would have to spend more than one month's income on prescription drug cost sharing.

Furthermore, I believe that in addressing the low-income provisions, conferees must add language that will allow for full participation of the U.S. territories within the Medicaid program. As you know, the U.S. territories' Medicaid programs are capped and any coverage provision extending aspects of these programs do not translate to the U.S. territories.

Again, to help close the disparities in our society, we ask you to urge the House-Senate conferees to support the Senate low-income assistance provisions. Adopting the Senate's subsidy provisions will make a major improvement in the lives of our nation's most vulnerable Medicare beneficiaries. Mr. Speaker, we need to pass a meaningful prescription drug plan that uses Medicare to make drugs affordable and provides a universal, voluntary benefit for all seniors. I urge my colleagues to support this motion to instruct.

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

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

There was no objection.

The SPEAKER pro tempore. The question is the motion to instruct offered by the gentleman from New York (Mr. BISHOP).

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

Mr. BISHOP of New York. 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.

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

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

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

The Clerk read as follows:

Mr. FLAKE of Arizona 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 within the scope of conference to include income thresholds on coverage.

The SPEAKER pro tempore. Pursuant to clause 7 of rule XXII, the gentleman from Arizona (Mr. FLAKE) and