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avoidably detained en route to the Capitol. Had I been present, I would have voted "aye."

MOTION TO INSTRUCT CONFEREES ON H.R. 4577, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2001

Mr. PALLONE. Mr. Speaker, I rise to offer a motion to instruct.

The SPEAKER pro tempore (Mr. THORNBERRY). The Clerk will report the motion.

The Clerk read as follows:

Mr. PALLONE 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. 4577 be instructed, in resolving the differences between the two Houses on the funding level for program management in carrying out titles XI, XVIII, XIX, and XXI of the Social Security Act, to choose a level that reflects a requirement on Medicare+Choice organizations to offer Medicare+Choice plans under part C of such title XVIII for a minimum contract period of three years, and to maintain the benefits specified under the contract for the three years.

The SPEAKER pro tempore. Under the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from California (Mr. THOMAS) each will be recognized for 30 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I yield myself 5 minutes.

Mr. Speaker, the motion I am offering is an amendment to inject some needed accountability into the Medicare+Choice program. It instructs the conferees to support language that would require HMOs participating in the Medicare+Choice program to stay in their given markets for 3 years. In addition, it instructs the conferees to support language that requires HMOs to provide all the benefits they promised to beneficiaries when they enrolled in Medicare HMOs.

Last week, the Republican leadership passed a Medicare refinement bill that is really nothing more than a special interest giveaway to the managed care industry. Over 40 percent of the money in this bill is given to the managed care industry, and it is given to the industry with virtually no strings attached.

Mr. Speaker, there is nothing in this bill that passed last Thursday that guarantees any stability for seniors or that the plans will stay in a given area. The only thing that is guaranteed is that the managed care industry will be granted a massive government windfall. I suppose it is a reward of sorts for the managed care industry from the Republican leadership for their effective campaign to prevent the patients' bill of rights from reaching the President's desk.

□ 1921  
So the joint resolution was passed.  
The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. MALONEY of Connecticut. Mr. Speaker, I was unavoidably detained during rollcall vote No. 574. Had I been present I would have voted "yea."

Additionally, I was unavoidably detained during rollcall vote No. 575. Had I been present I would have voted "yea".

PERSONAL EXPLANATION

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, on rollcall Nos. 574 and 575 I missed votes due to an airline delay. Had I been present, I would have voted "yea" on both.

PERSONAL EXPLANATION

(Mr. HINCHEY asked and was given permission to address the House for 1 minute.)

Mr. HINCHEY. Mr. Speaker, as a result of travel difficulties, on rollcall No. 574 and rollcall No. 575, I was un-

Unfortunately, the managed care industry's gain translates into a significant loss for Medicare beneficiaries and the entire spectrum of Medicare providers in the health community. Every Member in this Chamber has heard from providers in their districts, be it hospitals, home health care providers, nursing homes, hospices, community health centers and others, that are being crushed by the unintended financial burden of the balanced budget agreement. Despite last year's BBA refinement package, there are countless Medicare providers around the country whose ability to provide care to Medicare beneficiaries is precarious because of the lack of adequate reimbursement. In my district, I have already seen a hospital forced to close its doors.

Mr. Speaker, it would have been infinitely more appropriate to spread what money has been set aside in the budget for Medicare refinements more evenly throughout the program than to give a disproportionate sum to an industry that has a clear record of putting profits ahead of patients. Working with the White House, we will continue to fight for a more equitable distribution of funds so that the Medicare beneficiary, not the HMO executive, will come first.

It would have also been appropriate to require that the HMOs are held accountable for the care they are supposed to provide beneficiaries in exchange for the windfall the Republican leadership wants to give them. As we saw a few days ago, and as we have seen for the last several years, the Republican leadership is unwilling to break its special interest bond with the managed care industry. They remain steadfastly opposed to any measure that would require the managed care industry to act in a more responsible manner that Medicare beneficiaries and all patients have been demanding.

Mr. Speaker, let me also say that my motion is not an attempt to hamstring the managed care industry or weaken it in any way. I want to preserve it and make it stronger for all seniors who may want to enroll in HMOs for their care. In fact, I have introduced legislation myself that would restore funding to Medicare HMOs.

I am not, however, willing to simply give HMOs untold billions and then allow them to continue to pull the rug out from underneath seniors who are lured into HMOs with the promise of extra benefits. And this latter point about benefits is very important. Medicare beneficiaries are not just destabilized when their HMOs pull out of the market. They are oftentimes destabilized when their HMO stays and their HMO just rescinds the extra benefits that attracted the beneficiaries in the first place, the most popular example of that being prescription drug coverage.

Seniors should be afforded some peace of mind and be able to know that

when they enroll in an HMO for prescription drug coverage or whatever extra benefits they enroll for, they are going to get those benefits. If the Republican leadership remains wedded to giving the managed care industry multibillion dollar special interest giveaways at the expense of all other Medicare providers, the least the Congress can do is require that seniors are going to get what they are promised.

If my colleagues on the other side are as committed as they purport they are to providing seniors with a Medicare prescription drug benefit, they should have no opposition to requiring managed care companies to agree to provide what they promised beneficiaries they will provide for at least a 3-year period. I do not think that is a lot to ask for and that is what this motion to instruct is all about.

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

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

Mr. Speaker, I think first of all we should look at this motion to instruct. There are several levels of clearance that are required for a motion to instruct to be in order, and it has to deal with funding. Obviously, in this motion to instruct, it says that in resolving the differences between the two Houses on the funding level for program management of the Social Security Act. So it meets that test level.

But then it goes on to say that through the funding mechanism, they are supposed to choose a level that reflects a requirement on Medicare+Choice organizations to offer a minimum contract period of 3 years. There is no funding mechanism that would require or even allow a 3-year contract under Medicare. Medicare+Choice programs are funded for 1 year under the Health Care Financing Administration. The amount that a Medicare+Choice program receives is based upon a number of factors: where it is located, the cost of medical services in the area, and, most importantly, the makeup of the beneficiaries that have signed up for that Medicare+Choice program. That is, what is their age, what is their medical condition?

All of these factors are taken into consideration when the level of reimbursement to the Medicare+Choice plan is determined. The difference by the Medicare+Choice program of offering the statutory mandatory benefits is what the Health Care Financing Administration has determined to be its payment level. If there are dollar differences between those two areas, by law that plan must either offer additional benefits or that money has to be refunded back to the Health Care Financing Administration; but it can only be done on a 1-year basis under current law.

Beneficiaries can sign up for a Medicare+Choice program and leave

the program. That is, the patient profile of a plan can change from year to year. So it is nonsensical to think that a level of funding can produce a 3-year contract. It is also nonsensical to think that it can produce a set benefit package for a 3-year period. One of the reasons some of these plans are pulling out of areas is because they can no longer offer the benefits they had offered under their shrinking profit structure dictated and determined by the Health Care Financing Administration.

□ 1930

So make no mistake, not only does this motion to instruct have no legal binding requirement, but it is nonsensical. It is germane. It does affect the funding level. But in no way does just affecting the funding level bring about any ability to create a 3-year contract or a guaranteed 3-year level of benefits. It is just nonsensical.

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

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

Mr. ACKERMAN. Mr. Speaker, I would like to thank the gentleman from New Jersey (Mr. PALLONE) for taking the initiative on this issue, which is of a critical nature to our senior citizens throughout this country and specifically to our constituents who happen to live presently on Long Island in New York.

Mr. Speaker, I would just like to disagree with my learned colleague on the other side of the aisle who said that this is nonsensical. I think some of us read it in a different way that choosing a level that reflects a requirement, and the key word is a "requirement," on the Medicare+Choice organizations to offer plans that are no less than 3 years old. We think that that means that they can expend no funds other than to write a contract that would last 3 years. Anything else would be unacceptable under the language that we are offering.

Our senior citizens are in trouble in this country. They are not doing as well as so many other segments of society. There is so much uncertainty and insecurity in their lives that the instability that the current system offers them is totally unacceptable.

We approach things a little bit differently on Long Island, our congressional delegation that is, and we try to do things in more of a nonpartisan way when it affects our constituents. So we worked together, each and every one of us, Democrats and Republicans alike. And in the County of Suffolk, which is on the eastern end of Long Island, which I proudly share with our colleague, the gentleman from New York (Mr. LAZIO), we have a situation which is critical that is highlighted by this legislation.

Every single Medicare+Choice plan, with the exception of one, has announced that they are leaving Suffolk County because they are not being reimbursed quickly enough or adequately enough; and our senior citizens, those of the gentleman from New York (Mr. LAZIO) and mine, are absolutely traumatized. They do not know what is going to happen.

The one remaining plan has already announced they are going to have an additional \$75 premium each month. Somebody has to come down here to the floor and stick up for those senior citizens who are living in abject fear, whether they be in the district of the gentleman from New York (Mr. LAZIO) or my district on Long Island.

And those are not the only places. All of these, these are single-space lists of counties throughout the country where this problem is imminent right now. But in our county, that of the gentleman from New York (Mr. LAZIO) and mine, the announcement has already been made that they are packing up and leaving. They have given their 6-month notice.

These people have nowhere to go. There is but one plan left. What happens to my colleague's seniors? What happens to my seniors with the remaining plan if they are only limited to one more year? Where will these people go? They will have no coverage. And if that is the case, shame on each and every one of us for not providing to our constituents the protection that they need.

The constituents of the gentleman from New York (Mr. LAZIO) need it. My constituents need it. And the constituents of so many Members whose districts appear on these lists need it, as well.

Mr. THOMAS. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I would tell the gentleman that we certainly share his concern, but the idea of trying to get plans to stay for 3 years when there would be total uncertainty in the second and third year of what the contract might be will increase the chances of destabilizing the program, not decrease it, the exact opposite effect that the gentleman seeks.

For example, in the Med Pac report, March 2000, one concern "that may contribute to the lack of new plans and plan types and which may be discouraging current participants is uncertain future revenue streams for plans."

Mr. Speaker, I yield 3 minutes to the gentleman from Louisiana (Mr. MCCRERY), a member of the subcommittee.

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

Mr. Speaker, before I address the remarks of the last speaker on the minority side, let me just go over the numbers here so everybody has a clear

understanding of what we are talking about.

There has been some misstatements made in several quarters about the amount of money in this Medicare package for HMOs or Medicare+Choice program. Here we see the numbers laid out by the CBO for each category in this package.

For hospitals there is \$11 billion, 34.9 percent of the total package. Beneficiary assistance and preventive benefits, \$6.7 billion, 21.3 percent of the total package. And then we get to Medicare+Choice, the Medicare HMOs. There is \$6.3 billion in this package for Medicare HMOs, and that is 20 percent of the total package.

Now, I really believe that both sides on this issue are well-intentioned. I agree with the gentleman from New York (Mr. ACKERMAN). I think it is terrible that we have Medicare HMOs leaving certain parts of our country and, therefore, leaving those seniors with no coverage for things like prescription drugs, in some cases their deductibles, their copays, because those Medicare HMOs, those Medicare+Choice programs often provide those benefits.

I know in my district I had one Medicare HMO; and they left last year, the only one. I heard from hundreds of seniors in my district about that plan leaving. They wanted it back. They said that is the greatest thing we have ever had in Medicare, and we want it back. So I agree with the gentleman that we ought to try to encourage those plans to come to a locale and stay there.

But encourage is one thing; mandate is another. And in my opinion, I just have an honest disagreement with the gentleman as to how the market works. I think that if we mandate that a plan stays in a locale for 3 years, we will have fewer and fewer plans locating in those marginal locales where the reimbursement rate is at the margin for them to make a profit.

So it is an honest disagreement, but I think the gentleman who has offered the motion to instruct is just wrong about the effects of his motion if it were to become law.

And so for that reason, I would urge all Members on both sides of the aisle who are interested in having their seniors have access to these type Medicare plans to vote no on this motion to instruct.

Mr. PALLONE. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, what the gentleman from Louisiana (Mr. MCCRERY) is not mentioning is that there are buried or hidden indirect pass-throughs which are actually part of that chart. In other words, what happens is that money goes to the providers like the hospitals; and then it is passed through to the HMOs, about one-sixth of what goes to hospitals and other providers.

So it is still \$11 million, and it is still 40 percent of the total no matter how you cut it, and that is outrageous given that there are no strings attached.

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

Mr. THOMAS. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. MCCRERY).

Mr. MCCRERY. Mr. Speaker, I thank the gentleman for yielding me the time, and I will be glad to yield to my friend from New Jersey.

Mr. Speaker, the gentleman is right, there are interactions with the increased payments that we make to hospitals. Because, as the gentleman knows, in figuring the payment rate for the Medicare+Choice plans, it is the fee-for-service rate in that region that has an impact on the reimbursement rate for the Medicare+Choice program. That is true.

But certainly the gentleman would not suggest that we not raise the payments to the hospitals and the other providers that we are doing in this bill, would he?

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

Mr. MCCRERY. I yield to the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, the bottom line is that the HMOs are getting \$11 million, 40 percent of the total, no matter how you cut it.

Mr. MCCRERY. Mr. Speaker, reclaiming my time, but the gentleman is not suggesting that we should not be raising the reimbursement rate to hospitals and other providers?

Mr. PALLONE. Mr. Speaker, if the gentleman will continue to yield, no.

Mr. MCCRERY. Mr. Speaker, then as a natural consequence, we are going to get higher reimbursement for the Medicare+Choice plans. That is an interaction that is unavoidable in this plan. I am glad that the gentleman is not suggesting that we do not give higher reimbursement rates to our hospitals and other providers.

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

Mr. Speaker, I am just pointing out that the \$11 million figure and the 40 percent that goes to HMOs still stands. The gentleman was trying to contradict that and he cannot.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I thank my colleague from New Jersey and the Chair of our Democratic Task Force on Health Care for having this motion to instruct.

In a way I agree with my colleague from Louisiana that this may not be the best way to get the attention of the HMOs that predominantly serve our seniors. But it is our only battle tonight. And hopefully there is another way we can get their attention instead of just throwing more money at it.

HMOs only cover about 15 percent of our senior citizens. And yet, the bill we

voted on last week would provide at least 40 percent and over 10 years 47 percent to HMOs for those 15 percent. Actually, in Houston, we have a little over 15 percent of our seniors who are served by an HMO.

I have a similar problem that my colleague from New York has. In Houston, Texas, we are down to one HMO left and they are capped, because they do not have the network to be able to add more seniors to it. So, as of December 31, our seniors will not be able to have access to an HMO.

Now, I am not real thrilled about HMOs to begin with. But let me tell my colleagues what happened in Houston, Texas. We at one time had four or five HMOs. But one big insurance company, and I will not name them because they have done this around the country, they bought up the other HMOs. They bought up NYLCare 65, Prudential. And then they served notice a little less than 6 months or maybe a little more than 6 months later that they are not going to serve the market.

That is what HMOs are doing. That is our only way to do this is to make them stay in the market because they actually controlled over 65 percent of the market, and then they announced they are not going to serve it. That is not doing a service to my seniors in Houston any more than they are doing it to Long Island, and that is what is frustrating.

The Medicare BBA provider bill last week actually gave 40 percent and then 47 percent. A lot of us voted against this bill simply because of that. We need to provide more for hospitals and for providers and for doctors and for home health care, you name it. But if we are going to provide more for HMOs, and I do not mind it, I voted for it last year in 1999 and I will vote for it again, but let us put some restrictions on them. Maybe not 3 years, but let us do something instead of just giving them a blank check and then they still will not serve the seniors in my district.

Mr. THOMAS. Mr. Speaker I yield 4 minutes to the gentleman from Tennessee (Mr. BRYANT), a member of the committee that shares jurisdiction, the Committee on Commerce.

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

Mr. Speaker, I thank my colleagues from the other side who have talked about a spirit of bipartisanship and something I certainly agree with. I am concerned that this bill is going to be vetoed by the President. In the spirit of bipartisanship, I would ask my colleagues on the other side and our Vice President, who is from Tennessee, not to allow this to happen, to go to the President and to ask him to sign this bill.

Because my State of Tennessee really needs this legislation. Our Medicare beneficiaries in Tennessee will receive

\$4.3 billion that will help reduce their Medicare copayments, the money they have to pay out of their pockets and other assistance, as well as they need the \$1.4 billion that this bill provides for new preventive benefits under the Medicare program. And our Tennessee hospitals need this legislation also.

Altogether, this bill will benefit hospitals to the tune of nearly \$14 billion through direct and indirect funding. If our hospitals in Tennessee are forced to close or cut services, the effect on our patients and on the more than 52,000 hospital employees could be devastating.

I also want this bill not vetoed because it contains \$1.6 billion in critical funding for nursing homes and \$1.8 billion for home health care and hospice service. The legislation also expands Medicare coverage for telemedicine services. This is important to the rural areas of the State of Tennessee that I represent.

Using today's cutting edge technology, telemedicine or telehealth has the potential to revolutionize the way we practice medicine in this country, and it has the potential to erase the disparities in medical care and quality of care between rural areas and urban areas.

And last, but not least, I would hope the Vice President would realize about his home State of Tennessee that, without this legislation, we will lose in Tennessee \$27 million for our State's children's health insurance program, or the S-CHIP program.

Because Tennessee had already covered many of our S-CHIP eligible children under our State Medicare waiver program, Tennessee has had to work much harder to get children to enroll in S-CHIP. As a result, it has taken us longer to use all of the money allotted to the State for the S-CHIP program.

□ 1945

I hope the Vice President realizes that this bill will allow Tennessee 2 more years to use most of its S-CHIP money so that more Tennessee children can be covered. Now I know that our Vice President, Mr. GORE, spent a lot of time on this campaign trail talking about health insurance for children in Texas but, Mr. Speaker, I hope the Vice President will consider the needs of Tennessee's children in his discussions with the President about whether or not to sign this bill.

I urge my colleagues to vote against this motion to instruct and I urge the President to sign H.R. 2614.

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

Mr. TURNER. Mr. Speaker, I am glad to hear the gentleman from Tennessee (Mr. BRYANT) express his concern about his rural hospitals and his health care providers in his district because I have the very same concern, and that is why

I hope that he will join with us in urging this Congress to put a larger percentage of the increased funding for Medicare in increasing those reimbursement rates to those rural hospitals and to those rural health care providers instead of giving about 40 percent of it directly to the insurance companies that we do not even know if they will be passing that money along to those rural hospitals. That is why I oppose the Medicare funding plan that the Republican leadership has put before this body.

The truth of the matter is, Medicare+Choice HMO insurance plans are not working for our seniors and they are not working for the taxpayers. The bottom line is, in my district, as I went around in August talking to my seniors at town meetings, they stood in lines to tell me that their Medicare+Choice plans have been cancelled. In fact, 5,000 of them in my district received notices of cancellation just a month ago, and the truth of the matter is Medicare+Choice is being cancelled all across this country. That is why we need greater accountability, and that is what this motion is addressing.

Thirty percent of all Medicare beneficiaries in this country will have no Medicare+Choice option. Last year, 328,000 seniors got these notices of cancellation. This year almost a million seniors got notices of cancellation.

If one has looked at the recent General Accounting Office report on Medicare+Choice plans which was just issued, it will reaffirm the case that I am making tonight that our HMO plans are failing our seniors and our taxpayers.

Listen to this from the summary of the GAO report: Industry representatives contend that the Balanced Budget Act's payment rates are too severe and that low Medicare payment rates are largely responsible for the plan withdrawals. However, since the BBA was enacted, Medicare+Choice rates have risen faster than per capita fee-for-service regular Medicare spending. In addition, many plans have attracted beneficiaries who have lower than average expected health care costs while Medicare+Choice payments are largely based on the expected costs of beneficiaries with average health care needs. The result is that Medicare can pay more for a beneficiary who enrolls in a plan than if the beneficiary had remained in regular fee-for-service Medicare. As we, the GAO, recently reported, these additional payments amounted to \$5.2 billion or 21 percent more in 1998 than the fee-for-service program would have spent to provide Medicare coverage benefits to plan enrollees.

The plans offered by the HMOs are costing the taxpayers more money than regular Medicare and increasingly those HMO plans are withdrawing from

our seniors, and they need to have something better. That is why we fought for a prescription drug benefit under regular Medicare, which works for our seniors.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH), a member of the Committee on Ways and Means.

Mr. ENGLISH. Mr. Speaker, briefly I urge my colleagues to vote against this perverse and misguided motion to instruct. I agree the trend of Medicare+Choice plans pulling out of areas across the country is enormously disturbing, but may I suggest to the folks on the other side that they have offered exactly the wrong solution. By forcing plans to commit to 3 years, we are ensuring that plans who are struggling to maintain their service will leave now, right now. Medicare+Choice funding, as the gentleman from California (Mr. THOMAS), noted, is too unpredictable under current HCFA policy.

This motion adds no accountability; just a poison pill. I find it ironic that the Democrats and the President have spent the past week tearing apart the Medicare bill that this House passed, calling the money spent on Medicare+Choice plans unjustified. If anyone thinks that the money dedicated to shoring up Medicare+Choice plans is unjustifiable, I invite them to come to Erie, Crawford, and Mercer County, Pennsylvania. I invite them to explain that to seniors who are facing copays that will double in January and decrease benefits.

If they are indeed serious about stabilizing Medicare+Choice, then I urge our friends on the other side of the aisle to drop this and urge the President to sign the House package and work with us to ensure that seniors relying on these plans continue to have access to quality health care. Do not simply adopt populist poses and deploy vacant partisan rhetoric while requiring Medicare+Choice plans to be at the mercy of HCFA for 3 years. This is no solution. They will simply leave and seniors will be left holding the bag.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BROWN), the ranking member of our Subcommittee on Health.

Mr. BROWN of Ohio. Mr. Speaker, I thank my friend, the gentleman from New Jersey (Mr. PALLONE), for his leadership on this issue.

Mr. Speaker, December 31, 1998, Medicare managed care plans dropped 400,000 Medicare beneficiaries. December 31, 1999, Medicare managed care plans dropped 327,000 beneficiaries. On December 30 of this year, Medicare managed care plans will again unceremoniously drop 900,000 more senior citizens. Seniors in my district were dropped by United Health Care in 1998. Some switched to QualChoice, which dropped them in 1999. Some switched to Aetna, which will dump them at the end of this year.

A Medicare HMO is not real insurance. It is a roll of the dice that calls itself insurance. Why is the plus choice program failing seniors? Ask the HMOs and they will say it is because the Federal Government is underpaying and overregulating them. Ask the Inspector General and ask the General Accounting Office, and they will say we are actually overpaying and underregulating Medicare HMOs. They choose to hoard the profits they make in some counties while dumping those in less profitable counties.

This does not make them bad. It makes them businesses. It does, however, throw a wrench in it-is-all-the-government's-fault campaign that they are waging. If we are going to pay the managed care industry more, we owe it to beneficiaries and to taxpayers to demand that HMOs act responsibly towards those senior citizens who have enrolled in their plans. That means once HMOs enter a county, they should agree to stay put and they should agree to offer predictable benefits for at least 3 years. That way senior citizens will finally know exactly how long they can depend on their managed care plan. Before we hand over \$10 billion, almost half of the new Medicare dollars this Congress is appropriating, before we hand over \$10 billion of taxpayers' money to HMOs, before we hand over one dollar, we should do at least that much for beneficiaries. Support the Pallone motion.

Mr. THOMAS. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the gentleman from Ohio (Mr. BROWN) should know, and perhaps he does not, that in the language of the Medicare provisions that were passed last week included was language requested by the Health Care Financing Administration and the Clinton administration, which we agreed with, which we think is appropriate. The language says any dollars contained in this bill as an increase to Medicare+Choice programs must, must go to the beneficiaries in lowered premiums or increased benefits.

Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. WHITFIELD), a member of the Committee on Commerce and someone extremely interested in this issue.

Mr. WHITFIELD. Mr. Speaker, I am delighted that we are having this discussion tonight about this important issue and, of course, as we move closer to an election it is politically wise, I believe, to attack HMOs. And we recognize that all HMOs, there are some deficiencies there but also I think we must recognize that HMOs play a valuable part of providing health care to people throughout America. As a matter of fact, HMOs for our senior citizens are the only entities offering prescription drugs today, offering eye glasses today and so there are many benefits from HMOs that seniors receive.

There has been some discussion this evening about placing mandates on HMOs, and obviously we do need some mandates, but excessive mandates are not the answer. We have learned that lesson all too well in the State of Kentucky. Our Governor, about 6 years ago, placed such heavy mandates on the insurance companies offering health insurance in Kentucky that every one of them left, with the exception of one, and the insurance premiums in Kentucky skyrocketed and the number of uninsured in Kentucky skyrocketed because of mandates.

Now we can solve the health care problems in America today, but we cannot blame it all on the HMOs. We cannot blame it all on HCFA. But we have to work together. It is a complex issue, and I think that we can solve it.

I am particularly disappointed, however, that so many on the other side of the aisle and the President is now threatening to veto this bill that provides additional money for Medicare, about \$31 billion, \$6.5 billion to strengthen the Medicare+Choice program; more than \$500 million in increased funding for diabetes treatment, nearly \$500 million to the Ricky Ray Fund to compensate hemophiliacs, more than \$12 billion to strengthen hospitals, particularly rural hospitals. So I would urge the defeat of this motion to instruct.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise to support the motion to instruct by the gentleman from New Jersey (Mr. PALLONE). I thank the gentleman very much for his leadership.

Mr. Speaker, it is interesting, as I have listened to this debate, I heard the distinguished gentleman from Pennsylvania (Mr. ENGLISH) make the comment that is absolutely true. They will simply leave, and that is why we are on the floor this evening because the HMOs around this country have simply left. They have left with no admonishing, no requirements, no responsibility, no concern and no compassion; whether it is conservative compassion or liberal compassion.

I have in my hands pages and pages of those who have left Harris County, and when I go to my senior citizen meetings all of them are looking at me with incredulity asking the question, why are the HMOs closing. And so I believe this is a very instructive and very important motion to instruct, because the good gentleman from California (Mr. THOMAS) mentioned a provision that was put in, the stabilization fund, he knows full well that there is no requirement for those dollars to go back to the beneficiaries. The HMO can sit on those dollars forever and forever and forever.

It is interesting, I heard the gentleman from New York (Mr. ACKERMAN)

speak about his district. He mentioned the district of the gentleman from New York (Mr. LAZIO). My good friend, the gentleman from Tennessee (Mr. BRYANT), mentioned the HMOs closing in his district. They are closing in my district. What we are talking about here is responsibility, and to refer to the fact that it is only a 1-year contract that is incorrect, because the language in the regulation says at least 1 year. It does not say only 1 year. It says at least. That means it can go up to 2 years or 3 years.

In addition, Mr. Speaker, might I say that there is some conversation about this actuarial language in the bill; and I hope the President does veto it, in the tax bill. When we call the chief actuary and talk about them reviewing HMOs, he already has 30 people working overtime. He says he needs another 20 to be working to do what this tax bill wants him to do.

This is wrong directed and wrong headed. I want two things out of this tax bill. I want my hospitals to remain open, particularly my public hospitals; and I do not believe we should be giving \$34 billion to HMOs where only 15 percent of the seniors are actually enrolled. Give them an obligation to stay in our communities, and I might consider their tax bill.

Secondarily, give us the money to keep our public hospitals and our private hospitals open. When I talk to my constituents, they knew they could not work with the amount of money we had in this tax bill. It does not help home health centers, nursing homes, hospitals. It does not help anyone but the insurance companies. I believe this bill should be vetoed so the senior citizens all over this Nation can have HMOs that will stay in their communities with the requirement to sign a contract for 3 years and the doors of our hospitals will stay open to help the people who are really in need, and that compassionate conservative or conservative compassion, whatever it is, is really a reality that works for the American people. That is what we should be doing here and doing it today.

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Mr. THOMAS. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I would tell the gentleman that a letter from the American Hospital Association said, "We are urging Members to vote in favor of this legislation and we recommend that the President not veto this legislation," along with 48 other organizations, many of them providers.

I am a bit perplexed by the gentleman's \$34 billion number going to Medicare+Choice programs, since the Congressional Budget Office score of H.R. 5543 says the total spending over the 5-year period is \$31.5 billion.

Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr.

HAYWORTH), a member of the committee.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from California for yielding me time.

Mr. Speaker, listening to this debate tonight, and mindful of the reality of where we stand on the calendar, Mr. Speaker, here we are again with, sadly, my friends on the left apparently attempting to put politics before people. Perhaps it is not intentional, a misunderstanding, a misquoting of figures.

Believe it or not, despite the discord and debate, I do hear some common themes. I do hear friends on both sides of the aisle saying that health plans are crucial for seniors. Indeed, my friends on the left seem to be swearing by these HMO-Medicare+Choice programs, even as they swear at them. So if we agree that these programs are important, why do we not work now to save them?

That is what this House did last week, Mr. Speaker, with the legislation we passed, with the majority of funds going to hospitals. Of special concern to me are rural hospitals across the Sixth Congressional District of Arizona.

Indeed, Mr. Speaker, based on the fact that people knew we were working on this, the gentleman from the Fifth District of Arizona and I, working with our colleagues in the Senate, actually got a decision reversed on a health care provider preparing to leave Pima County.

Now, when we try to set arbitrary guidelines here, what we are doing is padlocking the insurance provisions. What we are doing is trying to stack the deck, and, in the process, kill the very thing we want to see happen.

Mr. Speaker, I would implore those on the left to put people before politics. We have a solution here and now that can work, that can keep insurance programs in place for seniors who have come to depend on those programs. That is why we must defeat this motion to instruct conferees and move forward with the legislation we passed.

Mr. PALLONE. Mr. Speaker, I yield 15 seconds to the gentleman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, let me just say the American Hospital Association may be supporting it, but I have a letter indicating that the Texas Hospital Association is against it, as are the Greater New York Hospital Association, the California Healthcare Association, the Massachusetts Hospital Association, New Jersey is against it, and the Health Care Association of New York State.

So I do think we have some disagreement. This bill should be vetoed.

OCTOBER 19, 2000.

[Letters to the Editor]

THE NEW YORK TIMES,  
New York, NY.

To the Editor:

Re "Medicare Bill That Favors H.M.O.'s Faces a Veto" (Oct. 18): The Balanced Budget Act of 1997 (BBA) enacted unprecedented and damaging funding cutbacks to hospitals and other health care providers throughout the country. These federal cutbacks are doing serious—and possibly irreparable—damage to our country's health care providers. Now it appears that Congressional leaders are putting forward a BBA relief package that provides disproportionate funding to the HMOs at the expense of desperately needed relief for hospitals and other health care providers. We, who collectively represent more than 1,800 hospitals and other health care providers, applaud the Clinton Administration's call for meaningful bipartisan action to restore urgently needed funds to health care providers. We have consistently supported bipartisan legislation in the Congress, sponsored by a majority in both Houses, which reflects the urgency of desperately needed Medicare funding restorations. Bipartisan leadership and action is needed before Congress adjourns.

Sincerely,

GARY S. CARTER,  
President, New Jersey  
Hospital Association.

C. DUANE DAUNER,  
President, California  
Healthcare Association.

RONALD M. HOLANDER,  
President, Massachusetts  
Hospital Association.

KENNETH E. RASKE,  
President, Greater New  
York Hospital Association.

DANIEL SISTO,  
President, Healthcare  
Association of New  
York State.

TERRY TOWNSEND,  
President, Texas  
Hospital Association.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentlewoman from Florida (Mrs. THURMAN).

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

Mr. Speaker, I just listened to the last speaker on the other side. Do you know what my seniors are telling me at home? They are telling me they want stability. They are tired of joining a plan, having to give up their traditional providers and their Medigap insurance just because the plan offers extra benefits, and then have the plan abandon the extra benefits the very next year or in fact just pull out in general. They are tired of this.

Mr. Speaker, I would say to the gentleman from California (Chairman THOMAS), the gentleman knows I came to the committee and I asked for a 2-year non-pullout time. I said, "Do you know what? My constituents, the ones that I sat in an open forum with, said to me, 'We do not want to lose this because we have problems. We are sick.

We need to have stability. We want you to go up there, Mrs. THURMAN, and we want you to fight for at least 2 years. Let us at least have 2 years, so that we can have some stability in our plan.'"

Well, do you know what? We offered that, and it was defeated. Tonight we are on the floor offering a 3-year. But, do you know what? I just found out something. How many of you have gotten letters in your district from your constituents who have gotten letters from their Medicare+Choice programs that have said, you know what? Your Congress needs to give us more money.

So do you know what we are doing? We are giving them more money, and all we are asking back is one simple thing: stay there for 2 years. Let us not keep pulling people in and out of that.

But let me tell you what is happening to them. Profits, third quarter profits in one company, was 26 percent. Third quarter profits. But listen to what happened. This is a letter from a constituent that has a plan. Their monthly plan premium is going from \$19 to \$179, \$19 to \$179. That does not include what they are going to get from whatever we pass to them. Outpatient, \$10 visit copayment to \$15. Outpatient hospital, \$20 to \$35. Under inpatient hospital care, they had no copayment in 2000. Now it is going to be \$200 per day, a limit of three copayments per year. Inpatient hospital stay, no copayment last year, now \$500 copayment per admission. Then prescription drugs, they even get a lesser prescription drug benefit.

Two years, three years, let us pass this motion.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 4 minutes to the gentleman from Louisiana (Mr. TAUZIN), a senior member of the Committee on Commerce.

Mr. TAUZIN. Mr. Speaker, I thank my friend for yielding me time.

Mr. Speaker, I think it is time we put this in perspective. Medicare+Choice programs are exactly that, they are Medicare plus, and they are choice programs. Nobody forces a senior to join them; nobody says you have to join it; nobody says you have to stay in it if you do not like it.

In fact, seniors join these Medicare+Choice programs because they like them, because they add new benefits, primarily prescription drug coverage, but sometimes even other nice benefits. Prescription drug benefit coverage obviously is something seniors want to have, and that is why this House passed a prescription drug benefit bill and sent it on to the Senate.

But for those seniors who join these programs, of course we all agree that we do not want these programs to shut down and move out. They have shut down in my district. They are threatening to move out in my district as well.

But the reason cited as the most important reason why they are moving

out, according to the MedPac March 2000 report, is the uncertainty of future payments. So can we all agree that the problem of reimbursement is one of the principal causes of hospitals shutting down in the rural parts of America and Medicare+Choice programs moving out?

So we pass the bill, H.R. 5543, which includes new reimbursement formulas, new monies to hospitals, new monies for the Medicare+Choice programs; and as the gentleman from California (Mr. THOMAS) correctly pointed out, it included language that said the money that went to the Medicare+Choice programs must be used for lower premiums and/or more benefits. It has to be used for that. So we provided more money to keep them there, to keep them home, and to keep them investing in our communities, providing these Medicare+Choice programs for seniors. We want to encourage them to stay.

The problem with the motion to instruct is that it may have the perverse effect of destabilizing them even more. What it says is you have to stay for 3 years, whether or not the program is working, whether or not the reimbursements are adequate to cover the benefits that are provided under the program.

The reason why this motion to instruct is wrong, even though we all agree that these are good programs that seniors want to have, even though we all agree that we do not want to see them move out of our districts, even though we all agree they are programs that provide extra coverage for our moms, for our dads and for our grandparents who desperately need extra coverage, the reason why this motion to instruct is wrong is it has the effect of destabilizing the presence of Medicare+Choice programs in our communities.

Why would someone come into a marginally profitable area? Why would they come into an area where the reimbursements are not quite adequate to cover the benefits? Why would they come in if they were told, whether or not it works, you have to stay 3 years? They would not come in at all. The chances of them not coming in, not being present for my mom, not being present for our grandparents around America, to have these programs available to them, is much stronger if this motion to instruct passes.

On the contrary, we ought to encourage the signature on H.R. 5543. Let me remind my friends on the other side, you voted to give more money to Medicare+Choice programs. You voted under the Medicare prescription drug bill we passed, or the Stark substitute. You voted for \$3 billion more to go to those programs. So you agree with us we ought to help them more, we ought to stabilize them, we ought to encourage them to stay so seniors can have them.

But what we ought not do in this motion to instruct is further discourage them, further say there is a bigger risk in your coming to Thibodaux, Louisiana, where seniors would like you to be around. You see, there is a disconnect here. You cannot on the one hand attack these programs and refuse to help them out financially, and then on the other hand say that whether you make it or not, you have got to stick around for 3 years.

Mr. Speaker, this is a bad motion to instruct. We ought to defeat it.

Mr. PALLONE. Mr. Speaker, I yield 3¼ minutes to the gentlewoman from Connecticut (Ms. DELAURO).

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

Mr. Speaker, this debate is about holding HMOs accountable. It is about accountability. The Republican leadership does not want to hold HMOs accountable. They in fact would like to reward them for outrageous behavior.

Evidence: The Patients' Bill of Rights, HMOs are making medical decisions all of the time. Some of those decisions go wrong. We have tried to pass a Patients' Bill of Rights in this body. The Republican leadership has held that up. All we are asking is if they make a medical decision that goes wrong, that they are held accountable.

Let us take a look at this bill that we are talking about this evening. Medicare HMOs should stop breaking their promise to seniors. When a senior signs up with a Medicare+Choice plan, they should have the security of knowing they will not see their coverage reduced or dropped for at least 3 years. We should be able to protect our seniors from those Medicare HMOs that are pulling the rug out from under them.

These were the folks that were supposed to provide seniors with more choices, with prescription drug coverage that seniors cannot get through traditional Medicare, but they are giving seniors no choice at all.

Let me talk about my State of Connecticut. They have jettisoned 56,000 people. I went to Milford, Connecticut, to a senior center, to say to these people, do not get scared. You can go back to traditional Medicare. We came to allay your fears.

A woman raised her hand and she says, Rosa, do not tell me not to be scared. I am scared. You have insurance. I do not have insurance. What am I going to do?

That is what this is about, accountability, HMO accountability. Instead of protecting seniors, Republican Congress protects the Medicare HMOs. We should have passed a bill here last week that would have provided desperately needed funding to our Nation's hospitals, rural, urban, home health, hospice providers. They faced deep cuts in 1997. They need that kind of help from us.

Instead, the Republican Congress turned this bill into an \$11 billion early Christmas present to the Medicare HMOs, 40 percent of the money in the bill, even though they only serve 15 percent of the seniors. They did it without any single guarantee that the Medicare HMOs will not stop reducing benefits or dropping seniors' coverage altogether.

Mr. Speaker, we should have learned something from the last time we increased the payment to Medicare HMOs. Last year we gave them an additional \$1.4 billion. Let me tell you how they returned the favor; they dropped nearly 1 million seniors. That is why we are asking here for tonight for the HMOs to have some guarantee that they need to stay for 3 years.

One more item. My Republican colleagues would go one step further. They would put the prescription drug benefit into the hands of HMOs; imagine, people who decided to cut the rug out from 1 million people.

Mr. Speaker, this motion says if Congress is going to give \$11 billion to Medicare HMOs, then Medicare HMOs should provide seniors with the coverage they promise. Keep faith with America's seniors and support the motion to instruct tonight.

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Mr. THOMAS. Mr. Speaker, it is now my very great pleasure to yield 3 minutes and 10 seconds to the gentlewoman from Connecticut (Mrs. JOHNSON), a member of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I would ask my colleague from Connecticut to read the bill and be honest with the seniors of Connecticut. Talk straight. The bill clearly sends every penny of new money to lower premiums or more benefits. Read the legislation.

The gentlewoman is right, our seniors are scared; and they have every right to be scared, because, my colleagues, when you push seniors out of Medicare+Choice, and you are going to with this kind of proposal, you are going to close up every plan within a month of passing this kind of legislation because the plans will have no choice. The seniors are scared because they are not going to be able to get into medigap plans. Most of them cannot afford them and those plans discriminate on the basis of preexisting conditions. Seniors will have no choice but Medicare, and they are in Medicare+Choice plans mostly because they are poor and need those copayments paid, and they are ill and they need a lot of care. So the seniors are afraid and this resolution will force many more plans to withdraw from the market realizing the greatest fears of our seniors.

My Democrat colleagues are going to close them up, because listen to what

they want to do. They want the plans to commit to stay in 3 years and cover benefits, and every year we increase benefits, and they are going to make them cover them, but they do not say one word in their amendment about paying for those benefits. Not one word.

Do my Democrat colleagues do their homework? Have they called their plans in the last year and asked them why they are losing money? Have they gone in and looked at the data that the plans have given them? Did it occur to my colleagues that when this body has given bigger increases to hospitals, nursing homes and home health cares every single year for the last 3 years and a 2 percent increase at maximum to our Medicare+Choice plans that they might be having trouble paying for the benefits that we want them to pay for? Of course. That is the problem.

That is why the Committee on Ways and Means Democrats voted with the Committee on Ways and Means Republicans to give these plans a 4 percent increase this year; and, as a result of the amendment of the gentlewoman from Florida (Mrs. THURMAN), because as she passionately described the fear and problems for her seniors if these plans go under, we gave them a higher increase, if they would come back into the market. Yes, we did that on a bipartisan basis, because we examined the facts. We talked to the plans, we talked to HCFA, we evaluated the information. That is our job on this committee with primary responsibility over Medicare.

Then, the President comes out and he says he wants 1 percent. Do we think they are going to stay in the markets with 1 percent when they have only been able to stay in the markets with the highest AAPCC at this time? And those happen to be the most densely populated markets, so they have the highest number of participants and it helps them stay in?

I am outraged, outraged that my Democrat colleagues would let politics bring this House floor to this level of dishonesty when they know that no plan will be unable to commit to 3 years and cover the benefits when they do not even guarantee them payment.

This amendment says nothing. It says negotiate. Well, the President wants 1 percent. Remember? The President said we only needed to add \$21 billion back to Medicare. The Republicans said no. We have to add \$28 billion back, or our hospitals will go under, our nursing homes will go under, our home health agencies will go under.

Give our seniors a break. Give our seniors a break. Give our health care providers the money they need to stay alive to not only serve our seniors, but serve the rest of the community that depends on our community hospitals, our nursing homes and our home care agencies. And yes, give them that choice of Medicare+Choice plans.

Mr. PALLONE. Mr. Speaker, I yield myself 30 seconds.

I just wanted to read from this report of the GAO that came out in September and it says, "Although industry representatives have called for Medicare+Choice payment rate increases, it is unclear whether increases would affect plans' participation decisions. In 2000, 7 percent of the counties with a Medicare+Choice plan in 1999 received a payment rate increase of 10 percent or more. Nonetheless, nearly 40 percent of these counties experienced a plan withdraw."

The bottom line is, the Republicans are saying they want to give all of this extra money to the HMOs. The minimum they could do is provide a 3-year guarantee and keep the benefits the same way, because otherwise, it will not work.

Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts (Mr. OLVER).

Mr. OLVER. Mr. Speaker, it is a hard act to follow from my colleague from Connecticut, but I rise in support of the motion to instruct. Rural areas like mine in western Massachusetts, and not so rural areas like the gentleman from New York (Mr. LAZIO) like Long Island, have been left high and dry by Medicare HMOs. They have largely abandoned rural markets to providing a prescription drug benefit for senior citizens, and those plans that do remain have raised premiums by as much as 300 percent in some cases.

Now, I support giving better reimbursements to health care providers that were harmed by the Balanced Budget Act. Hospitals, nursing homes, home health providers, and even HMOs need our help. But it makes no sense to me to give billions of dollars to HMOs, while allowing them to abandon senior citizens in rural America without coverage for prescription drugs. Such a handout to HMOs without holding them accountable is a reckless use of taxpayer dollars.

Mr. Speaker, if we are to give money back to the HMOs, we should have some guarantee that they will not take the money and run. We must add, we must require HMOs to offer a fair plan to all seniors for drug coverage that they desperately need.

Mr. THOMAS. Mr. Speaker, it is my pleasure now to yield 1 minute to the gentleman from Georgia (Mr. KINGSTON).

Mr. KINGSTON. Mr. Speaker, I want to speak to my friends on the other side of the aisle.

My dad is 82 years old. He has macular degeneration, and he has diabetes. That means he is legally blind, he cannot read his blood sugar level, and he is trying to live independently.

Now, I do not know what my Democrat colleagues think about when they play games with our seniors like my father, but it seems to me that there is a

consistent pattern around here for the last 3 weeks to put politics over people over and over again.

Here is a bill that has been endorsed by the American Hospital Association, the American Cancer Society, the American Federation of Home Health Care Providers, the National Association of Childrens Hospitals, the National Association of Rural Health Care Clinics, which I know they do not care about that, because the gentleman from Rhode Island (Mr. KENNEDY), their leader says, and I quote, "We have written off rural America."

Now, I know they are proud about that and I know what this is about, but the fact is, I would like my colleagues to think about people out there who have diabetes, people out there who are in nursing homes, people out there who yes, are scared, because you know what? It is November and every 2 years there are certain members of the Democrat party who cannot get reelected, so they get scared and they know the only way they can keep getting elected is to scare senior citizens. It is not right. I have a 97-year-old great grandmother. She does not appreciate putting politics over people. We are tired of it.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from New Mexico (Mr. UDALL).

Mr. UDALL of New Mexico. Mr. Speaker, I would say to the gentleman from Georgia (Mr. KINGSTON), first of all, that we believe in rural America and the reason the gentleman in New Jersey (Mr. PALLONE) is offering this motion is because we support rural America; and we want accountability. I rise in strong support of this motion.

Congress has a responsibility to protect seniors and stop protecting the HMO industry. This motion is designed to require accountability for Medicare HMOs. This issue is especially important to my home State of New Mexico. Earlier this year, between 15,000 and 17,000 New Mexico seniors were told that by year's end, they were being dropped from their Medicare+Choice coverage. Needless to say, a frantic plea for help rang out from seniors asking for a solution.

Mr. Speaker, I am opposed to the solution offered by the majority to shovel more and more money to HMOs; and I urge support of the Pallone motion.

Mr. THOMAS. Mr. Speaker, it is now my pleasure to yield 2 minutes to the gentleman from North Carolina (Mr. BURR), a member of the Committee on Commerce.

Mr. BURR of North Carolina. Mr. Speaker, I thank the gentleman from California for yielding me this time.

Mr. Speaker, I have sat and listened to this tonight and what misses out of this debate is the human face behind the issue. It is that senior who sits at home, that has no coverage; that senior who has a Medicare system that

this institution has refused to change year after year after year, that does not meet the needs of medicine today, the diagnostic tools that exist and the treatments that are available to those that can pay.

We ought to have a debate today about the changes in Medicare, but we are not. We are going to have a debate about how we hamstring choice for seniors, how we tie up the companies who can provide that choice so that, in fact, they will not, further taking seniors and limiting them to the existing system.

Now, the gentleman before me, the gentleman from New Mexico (Mr. UDALL) said that it is just about paying them more money. One of the reasons that they are dropping out of the system is that we underfunded this particular portion, and every Member bipartisanly has agreed to that. But the question is, is there accountability? Can they prove the value of their service? I believe that they can; I believe that this motion to instruct in fact hampers any additional plus choice options in the marketplace for seniors that either have been dropped or are currently underserved.

Mr. Speaker, I would encourage every Member to vote against this motion to instruct and to vote for additional choices for seniors with health care.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. DINGELL), the ranking member of the Committee on Commerce.

Mr. DINGELL. Mr. Speaker, facts are awfully hard to quarrel with. What are the facts? Last year, we gave the HMOs \$2 billion and more. This bill gives them \$34 billion and more. HMOs have pulled out. Last year they pulled out and left about a half a million Americans without coverage. They have pulled out on almost 1 million more this year. The motion to instruct says one thing, and that is, if you are going to take this money, stay for 3 years.

What is so hard for my colleagues on the Republican side to understand? This is simply about accountability. They are going to get a lot of Government money, and they ought to stay to take care of the senior citizens.

Now, perhaps that is hard for my Republican colleagues to understand; but it is not hard for the GAO or for the Inspector General of HHS who said that the HMOs are now being overpaid. They have got more money than they need, but they do not have enough to satisfy them.

Now, some of the statements that were made on this side of the aisle have really touched my heart, and I would be much impressed if they were true. They talked about these important unfortunate HMOs. Well, these poor HMOs are pulling out on America's senior citizens and leaving them without coverage. That is what they are doing. The motion to instruct says,

you are going to take a lot of Federal money, some \$34 billion or \$36 billion last year and this year, so stay around for a while and provide services. What is so hard for my Republican colleagues to understand about that simple fact?

Now, if I were crafting this bill, I would do it to really help the senior citizens. I would see to it that we put in a decent program for prescription medicine so that they have it. HMOs could take this money, they do not have to do anything for it, except put it in the pockets of their executives or to see to it that it goes into the bottom line in dividends.

I would see to it that it goes to hospitals, to home nursing, and to nursing homes, so that we can really help those who need it. That is how we do the job.

□ 2030

Mr. THOMAS. Mr. Speaker, I yield 1 minute to the gentlewoman from New Mexico (Mrs. WILSON), a member of the Committee on Commerce, who can tell my colleagues the real impact of this bill.

Mrs. WILSON. Mr. Speaker, the gentleman from Michigan (Mr. DINGELL) who just spoke talked how he would write this bill if he had the opportunity to, but the underlying bill went through the Committee on Commerce, and he voted for it.

The reason he voted for it is it is a bipartisan bill, and it is a good piece of legislation. I want to talk about the Medicare+Choice provisions because I was the author with the gentleman from Minnesota (Mr. LUTHER), a Democrat, of the underlying bill. Senator WYDEN and Senator DOMENICI were the authors in the Senate.

The biggest threat to eliminating the discrimination against States like New Mexico is not a motion to instruct. It is that the President of the United States has said he intends to veto this bill which will save health care coverage for a million Americans, 15,000 of whom live in New Mexico. And do my colleagues know who runs the HMOs in New Mexico? The Catholic church, the Presbyterian church, both of them running nonprofit corporations and Loveless hospital that has been serving our community for almost 60 years.

Mr. Speaker, I encourage the President of the United States to sign this bill and restore health care for America's seniors.

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

Mr. Speaker, I think we need to understand that the motion to instruct really ought to be, as the gentlewoman from New Mexico (Mrs. WILSON) said, to instruct the President to sign the bill. It is time to stop the politics. This is a bill that not only funds the providers, the hospitals, the home health care skilled nursing, but it creates a bi-annual test for Pap smears.

It screens glaucoma. It screens colonoscopy. It eliminates the time on

Medicare benefits for immunosuppressive drugs. It puts limits on prescription drug charges so seniors are not bilked by unscrupulous providers. Yes, and it tells the plans that if we provide them with money, that money must go to beneficiaries.

This motion to instruct is all politics, and the President's failure to sign the bill is all politics. Let us end the politics. Vote no on this motion to instruct and tell the President to sign the bill.

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

Mr. PALLONE. Mr. Speaker, I yield myself the balance of the time.

Mr. Speaker, this motion is to protect the seniors and make sure they do not get thrown out of their HMOs and they do not lose their benefits, including their prescription drug benefits. And what the Republicans want to do in opposing this motion is they want to give all this money to the special interest HMOs so they can use it for their executives, so that they can put more ads on to try to lure seniors in to a benefit plan that they are not going to really get, and so that they can use the money for special interests for lobbying and to lobby to come down here and avoid HMO reform and the Patients' Bill of Rights and a Medicare prescription drug program.

This bill that the Republicans have proposed is for the special interests. What the Democrats are saying with this motion is let us make sure that the seniors can stay in a program that they can get their benefits. We are worrying about the little person who is being thrown out of the HMO all over this country, including in my district.

Mr. Speaker, I had a woman that had to go to a dinner. She was lured to a dinner with advertising by the HMO to get into a program with a lobster dinner. They gave her a lobster dinner so she would sign up for the HMO, and then she is thrown out of the HMO and she has nowhere to go.

It is a disgrace. Vote for the motion to instruct.

Ms. VELÁZQUEZ. Mr. Speaker, I rise in support of the Pallone Motion to Instruct. This motion addresses yet another failure of the managed care system. The Medicare Plus Choice plans are currently constructed so that an HMO in the system can drop out at any time, leaving its patients to find another choice provider, or to re-enter the standard Medicare system. Often, this happens on very short notice.

This motion seeks to ensure that our frailest citizens do not suddenly find themselves kicked out of the system they depend on for their health coverage. Since January of 1999, this has happened to over 700,000 senior citizens nationwide. The Health Care Financing Administration estimates that over the next year, 10 to 15 percent of the nation's Medicare Plus Choice beneficiaries will find themselves in the same situation.

Therefore, we must support this motion to ensure that all providers offer coverage to

seniors for at least three years after they join the system.

More importantly, rather than trying to mend an already fraying safety net, we need to pass comprehensive legislation—in particular, a patient's bill of rights to protect all Americans. If we had done this in this Congress, HMOs would already have been put on notice that we will not allow them to place profits over the health of people.

Last October, 275 Members of this House, from both sides of the aisle, passed a strong HMO reform bill. The Republican leadership has allowed it to die in conference, again thwarting the will of the House.

Even worse, Republicans are ignoring the demand of the American people for health care reform. They are also showing that they are more concerned about big business than the health of the American people.

My colleagues, we have a chance today to say that we will no longer stand by while the health of our senior citizens is sacrificed on the altar of corporate greed. If you agree, then I urge you to vote in favor of this motion.

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

The SPEAKER pro tempore (Mr. THORNBERRY). 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 New Jersey (Mr. PALLONE).

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

#### RECORDED VOTE

Mr. PALLONE. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 170, noes 183, not voting 79, as follows:

[Roll No. 576]

AYES—170

Ackerman	DeFazio	Holt
Aderholt	DeGette	Hooley
Andrews	DeLauro	Horn
Baca	Deutsch	Hoyer
Baird	Dicks	Inslee
Baldacci	Dingell	Jackson (IL)
Baldwin	Dixon	Jackson-Lee
Barcia	Doggett	(TX)
Barrett (WI)	Doyle	Jefferson
Bentsen	Edwards	John
Berkley	Emerson	Johnson, E.B.
Berman	Engel	Jones (NC)
Berry	Eshoo	Jones (OH)
Bilbray	Etheridge	Kildee
Blagojevich	Evans	Kind (WI)
Blumenauer	Farr	Klecza
Bonior	Fattah	Kucinich
Borski	Filmer	Lampson
Boswell	Ford	Larson
Boyd	Frost	Leach
Brown (OH)	Ganske	Lee
Capps	Gejdenson	Levin
Capuano	Gephardt	Lewis (GA)
Cardin	Gilman	LoBiondo
Carson	Gonzalez	Loggren
Clement	Green (TX)	Lowe
Clyburn	Hall (OH)	Lucas (KY)
Condit	Hall (TX)	Luther
Costello	Hill (IN)	Maloney (CT)
Coyne	Hinches	Maloney (NY)
Cramer	Hinojosa	Markey
Cummings	Hoeffel	Mascara
Davis (FL)	Holden	Matsui

McCarthy (MO)	Phelps	Smith (NJ)
McCarthy (NY)	Pomeroy	Stabenow
McDermott	Price (NC)	Stenholm
McGovern	Rahall	Strickland
McKinney	Rangel	Tanner
McNulty	Reyes	Tauscher
Meeks (NY)	Rivers	Taylor (MS)
Millender-	Rodriguez	Thompson (CA)
McDonald	Roemer	Thurman
Miller, George	Rothman	Tierney
Mink	Roukema	Towns
Moakley	Roybal-Allard	Turner
Mollohan	Rush	Udall (CO)
Moore	Sanders	Udall (NM)
Morella	Sandlin	Velázquez
Nadler	Sawyer	Waters
Napolitano	Saxton	Watt (NC)
Neal	Schakowsky	Waxman
Obey	Scott	Weiner
Olver	Serrano	Wexler
Ortiz	Sherman	Wilson
Pallone	Shows	Woolsey
Pastor	Sisisky	Wu
Payne	Skeltton	
Pelosi	Slaughter	

#### NOES—183

Armey	Goodlatte	Pickering
Bachus	Goodling	Pitts
Baker	Goss	Pombo
Ballenger	Graham	Porter
Barrett (NE)	Granger	Portman
Bartlett	Green (WI)	Pryce (OH)
Barton	Greenwood	Quinn
Bass	Gutknecht	Radanovich
Biggert	Hansen	Ramstad
Bilirakis	Hastings (WA)	Regula
Bliley	Hayes	Reynolds
Blunt	Hayworth	Rogan
Boehert	Herger	Rogers
Boehner	Hill (MT)	Rohrabacher
Bonilla	Hilleary	Ros-Lehtinen
Bono	Hobson	Royce
Brady (TX)	Hoekstra	Ryan (WI)
Bryant	Hostettler	Ryun (KS)
Burr	Houghton	Sabo
Burton	Hunter	Salmon
Buyer	Hutchinson	Sanford
Callahan	Isakson	Scarborough
Calvert	Istook	Schaffer
Camp	Jenkins	Sensenbrenner
Canady	Johnson (CT)	Sessions
Cannon	Johnson, Sam	Shadegg
Castle	Kelly	Sherwood
Chabot	King (NY)	Shimkus
Chambliss	Kingston	Simpson
Chenoweth-Hage	Knollenberg	Skeen
Coble	Kuykendall	Smith (MI)
Coburn	LaHood	Smith (TX)
Collins	Largent	Smith (WA)
Combest	Latham	Souder
Cook	Lewis (CA)	Spence
Cox	Lewis (KY)	Stearns
Cubin	Linder	Stump
Cunningham	Lucas (OK)	Sununu
Davis (VA)	Manzullo	Sweeney
Deal	McCrery	Tauzin
DeLay	McHugh	Taylor (NC)
DeMint	McKeon	Terry
Diaz-Balart	Mica	Thomas
Doolittle	Miller (FL)	Thornberry
Dreier	Miller, Gary	Thune
Duncan	Minge	Tiahrt
Dunn	Moran (KS)	Toomey
Ehlers	Myrick	Traficant
Ehrlich	Nethercutt	Upton
English	Ney	Vitter
Everett	Northup	Walden
Ewing	Norwood	Walsh
Fletcher	Nussle	Wamp
Foley	Oberstar	Weldon (FL)
Fossella	Ose	Weldon (PA)
Frelinghuysen	Packard	Weller
Gallegly	Paul	Whitfield
Gekas	Pease	Wicker
Gibbons	Peterson (MN)	Wolf
Gilchrest	Peterson (PA)	Young (AK)
Goode	Petri	Young (FL)

#### NOT VOTING—79

Abercrombie	Bereuter	Campbell
Allen	Bishop	Clay
Archer	Boucher	Clayton
Barr	Brady (PA)	Conyers
Becerra	Brown (FL)	Cooksey

Crane	Kennedy	Pascarell
Crowley	Kilpatrick	Pickett
Danner	Klink	Riley
Davis (IL)	Kolbe	Sanchez
Delahunt	LaFalce	Shaw
Dickey	Lantos	Shaays
Dooley	LaTourette	Shuster
Forbes	Lazio	Snyder
Fowler	Lipinski	Spratt
Frank (MA)	Martinez	Stark
Franks (NJ)	McCollum	Stupak
Gillmor	McInnis	Talent
Gordon	McIntosh	Tancredo
Gutierrez	McIntyre	Thompson (MS)
Hastings (FL)	Meehan	Visclosky
Hefley	Meek (FL)	Watkins
Hilliard	Menendez	Watts (OK)
Hulshof	Metcalf	Weygand
Hyde	Moran (VA)	Wise
Kanjorski	Murtha	Wynn
Kaptur	Owens	
Kasich	Oxley	

□ 2055

Messrs. CANADY of Florida, ISTOOK and MINGE and Mrs. CHENOWETH-HAGE and Mrs. KELLY changed their vote from "aye" to "no."

So the motion to instruct was not agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

**HOUR OF MEETING ON MONDAY,  
OCTOBER 30, 2000**

Mr. REYNOLDS. Mr. Speaker, I move that when the House adjourns today, it adjourn to meet at 9 a.m. tomorrow for morning hour debate, and 10 a.m. for legislative business.

The motion was agreed to.

A motion to reconsider was laid on the table.

**MESSAGE FROM THE SENATE**

A message from the Senate from Mr. Lundregan, one of its clerks, announced that the Senate has passed without amendment a joint resolution of the House of the following title:

H.J. Res. 119. Joint Resolution making further continuing appropriations for the fiscal year 2001, and for other purposes.

**HOW MUCH IS ENOUGH?**

(Mr. HAYWORTH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HAYWORTH. Mr. Speaker, there is a simple question we confront tonight as we have moved in this common sense Congress to reach compromise and consensus in a bipartisan fashion. That is, after agreeing to many provisions on both sides of the aisle, with what some would call reasonable and others would call overly generous spending packages, Mr. Speaker, we are facing this question: How much is enough?

I would turn to the legislation we passed at midweek last week in this 106th Congress, reasonable plans that offered tax relief, but more impor-

tantly, ordered a Medicare refinement and restoration plan needed for our hospitals, needed for our home health care, needed for our nursing homes, and other provisions actually requested by the President of the United States who came to Arizona to embrace a new markets initiative, part and parcel of the bill we passed last week, and yet sadly so many people on the other side voted against it.

Mr. Speaker, how much is enough?

**HOW MUCH MORE DOES THE  
PRESIDENT WANT?**

(Mr. GUTKNECHT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GUTKNECHT. Mr. Speaker, I think a lot of the American people are surprised that the Congress is still in session. I think a lot of people back in my district cannot believe that we have not resolved our differences. This chart is a little hard to read, but it follows on with what the gentleman from Arizona was talking about. What it shows in red is what the President requested in each of his budget requests per category.

On Education, Labor, HHS, the chart is about the same. Agriculture, right on down the line. In fact, in one of the areas in the Defense budget we are actually giving more than he requested. By the time we are done with this bill that we debated so hotly tonight, at least the motion to instruct, we are going to give the President significantly more than he originally requested, which leads to the real question that not only we in Congress but the American people, and frankly, members of the working press, ought to be asking the President of the United States: How much is enough?

□ 2100

Now, we have been willing to meet with the President to negotiate in good faith. We have met him more than halfway. But we should not be in session today. How much is enough, Mr. President?

**PERSONAL EXPLANATION**

Mr. GREEN of Texas. Mr. Speaker, yesterday, October 28, 2000, I was unavoidably detained and missed two rollcall votes, Nos. 572 and 573. I would like the RECORD to reflect that I would have voted "yes" on rollcall No. 572 and "yes" on rollcall No. 573.

**CONGRESS FIGHTING BATTLE  
OVER BUDGET**

(Mr. EHLERS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EHLERS. Mr. Speaker, it is a pleasure to be here this evening. This

is an historic event. We have never met this late in our legislative season since World War II. But perhaps this is not all bad. We are fighting a battle here, too; and that battle is to keep the budget down.

Over the past few years, when we approached this point, the President demanded more spending. In order to wrap up this session and get home for elections, we capitulated.

This year we are not going to do that. The President is trying to shanghai us by saying, we will only let you go for 24 hours. You have to be here every day, even though there is nothing to do, because they are not negotiating.

I think it is rather unique. But we are here. We are willing to work. We are eager to work. Unfortunately, the President has been out on the West Coast raising money. But as soon as he gets back and as soon as he is willing to negotiate with us, we are ready and willing to negotiate. But we are not going to give the ship away. We are going to restrain the budget and do the best we can to keep the budget balanced.

**ISSUE IS NOT HOW MUCH MONEY**

(Mr. STENHOLM asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. STENHOLM. Mr. Speaker, the issue is not how much money. The majority voted last week to increase the caps to \$645 billion in spending. That is \$13 billion more than the President requested. The Blue Dog Democrats suggested a compromise of \$633 billion a long time ago. The majority refused to talk to us.

I hope we will stop talking about money. Money is no longer the issue. Because if we exceed \$645 billion cap for 2001, there will be sequestration and we will bring all the spending back to \$645 billion, which is what the majority has set for the caps, which is way too much spending.

So I hope we will stop this misdirected rhetoric tonight. Because that sign there "how much is enough?" has no relevance whatsoever to any of the issues that we are talking about because we all agree now that \$645 billion is the cap.

**PRESIDENT HAS DEMANDED  
BLANKET AMNESTY FOR ILLEGAL ALIENS**

(Mr. ROHRBACHER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ROHRBACHER. Mr. Speaker, the gentleman may or may not be correct in terms of what the issue is. The President always is pushing us to spend a little more on health care, a little