

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

Mr. CASE. Mr. Speaker, I offer a motion to instruct conferees on H.R. 1.

The Clerk read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Q) Section 452 (relating to limitation on reduction in area wage adjustment factors under the prospective payment system for home health services).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There was no objection.

The SPEAKER pro tempore. Pursuant to clause 7 of rule XXII, the gentleman from Hawaii (Mr. CASE) and the gentleman from Florida (Mr. BILIRAKIS) each will control 30 minutes.

The Chair recognizes the gentleman from Hawaii (Mr. CASE).

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

Mr. Speaker, by my calendar, we now have 16 days until the October 17th deadline announced by the President and the Senate majority leader for completing the pending conference on the so-called Medicare reform bill. And still before this House, before this Chamber and the Senate and the country the unanswered question, in my mind, is: Does the current administration and does the congressional majority really care about health care for the American people?

Now, I know a lot of people around here really care about a lot of people around here that make a lot of money off of health care. And I know that a lot of people around here really care about spending money on a lot of things other than health care. I have seen that in my time here in Congress. And I have certainly heard a lot of talk, a lot of talk about health care. I have certainly heard a lot of talk about Medicare. But the question is: Do they really care? What do their actions demonstrate? Do they care about the people at the end of this food chain?

It is a long food chain from the halls of this Congress through the Federal Government and out through the health care community and down into the communities where people live, work and get sick. Do they really care about the people at the end? All of us do not just want affordable and available health care; we need it, and it has to be available and affordable.

When we look at where the people of our country live, who most want and

most need health care, and when we look at where the assistance of our Federal Government should go, it is in the rural areas of our country, our small cities, our small towns, our hamlets, our isolated outposts, out where people live away from these urban centers where we live and do our work. And the reasons for that need are well documented, and I do not think anybody else has to tell us any more.

We all know why health care is so important to the rural areas of our country. First of all, we have less available preventive care throughout life, so when people get sick younger, they get sick worse in the rural part of our country. In the rural parts of our country today and down the road, people are older than in the urban parts of our country; they need health care more.

□ 1245

In the rural parts of our country people have lower incomes, higher unemployment, and when we have lower income and higher unemployment, health care suffers.

In the rural parts of our country, it always has been true that there has been less access to medical care and specialization, and that is getting worse.

Finally, in the rural parts of our country, there is simply less availability and coverage of health care insurance.

These are not just abstract thoughts. We can read about these in Federal reports. We can debate them here in Congress, but let us talk about real America, what happens out there in these communities, and let me talk about my community, the community that I represent, because I represent rural Hawaii. I do not represent downtown Honolulu. I represent the rural parts of my State, islands all of them, islands that are rural, islands with small cities, small towns, hamlets and outposts every bit as rural as the rest of our rural country, every bit as prone to all of these problems. They may have different names, but the concerns are the same.

Let me give my colleagues just a couple of examples of areas of my District which are just like any part of our country in terms of health care. Let us talk about the Hamakua Coast on the island of Hawaii, my home. The Hamakua Coast is about as rural as one can get in Hawaii. It is an agricultural-based economy. Its largest crop, sugar, failed along that coast 10, 15, 20 years ago. And these small towns now have people that grew up in the sugar industry and are trying to make a go of small business in agriculture in those small towns, small towns like Pepeekeo and Papaikou, Laupahoehoe, Paauiilo, Honokaa, and their problem is health care.

Let us take West Hawaii, the other side of the same island, a part of my Hawaii that has some most of the rural areas of our whole State, North

Kohala, Ocean View down in South Kona and Kau. They want those rural communities to survive. West Hawaii used to have a surgeon that qualified for Medicare reimbursements. That surgeon is no longer there. There is no surgeon in West Hawaii at the moment for Medicare people.

So when I walk into the coffee shops, when I walk into the small family stores and small post offices of my district, when I go into the bon dances that are so much a part of our culture during the summer, and I sit down, and I talk to my constituents, and I ask them what is on their mind, they say health care, health care and health care.

This is not an abstract thought. They are scared about the availability of health care. They are scared about the availability of prescription drugs. They are scared about chronic disease and chronic illnesses and their ability to be able to take care of their medical needs. They are scared about long-term care, and their children are scared for their parents.

These are the realities of rural America. The availability of physicians in this part of my district is significant in the example that it shows for what is happening in rural health care. There are about two physicians per 1,000 in urban Honolulu, but if one gets out there into the rest of the communities in my district, the percentage drops well below one, down to 0.1 in communities like Molokai.

Let us talk about Molokai, because that is another good example. The island of Molokai, about as rural as one can get in America, an island, an island of 7,000 people living on it. They cannot hop a bus or a train or a boat to get to some critical access hospital when they have medical care. They have to fly, and flying is expensive. Thousands of dollars are being spent.

Hawaii is no different from the rest of rural America. I fly over rural America almost every weekend. I look down. I have been across it myself, and I look out, and I see places just like my rural Hawaii. They are their own islands. They may not be surrounded by water, but they are islands of isolation, islands of small towns, small hamlets, the prairie towns of the great plains, the mountain hamlets of the Sierra, the Rockies or Appalachia. This is our heartland, and they are scared about health care.

In rural America, health care is not an abstract thought either. It is a Federal program, Medicare. Health care in rural America is Medicare. For seniors in rural America, it is Medicare. For the disabled in rural America, it is Medicare, and because in rural America it is health care and health care is Medicare, as Medicare goes, so goes rural America.

If we do not have available and affordable medical coverage through Medicare, we have no rural America. If we do not have adequate reimbursements, no doctors, no hospitals, no

clinics in rural America, we have no rural America. If we do not have adequate prescription coverage for our seniors and disabled that live in rural America through Medicare, we have no rural America.

So one of the things that it is incredibly important to realize is that the debate about Medicare is not just about Medicare. The debate about Medicare is not just about health care. The debate about America is about maintaining rural America. We have to take care of the needs of rural America, whether they are economic needs, where the manufacturing base is shrinking or whether they are land use needs, where the agricultural base is shrinking, and whether they are health care needs, where the needs are diminishing. That is the reality of Medicare.

H.R. 1, the Medicare Reform Bill, passed this House by a single vote. Like most of my colleagues on this side of the aisle, I voted no on that bill, primarily because that bill did not help rural America. That bill did not do the job for rural America that we wanted it to do, and in fact, that bill hurt rural America, and I voted no. The motion before us today simply says this: Put your money where your mouth is.

There has been a lot of talk about helping rural America, but talk is cheap. Let us prove it. Do not get me wrong, there are some components in both the House version of Medicare reform and the Senate version of Medicare reform, there are isolated instances of help for rural America in both bills. That is not going to be good enough. As these 16 days tick by to the deadline set by our President and our Senate majority leader, our attention has to turn back to what are the best aspects of each bill for rural America, what are the best aspects of the bill that help the particular problems in rural America, what are the aspects of the bill that provide prescription drug coverage, what are the aspects of the bill that provide adequate reimbursements to hospitals and doctors.

On the island of Molokai, for example, we no longer have long-term care beds. Why? They cannot provide them under the reimbursement rate granted by Medicare. That may seem like an abstract thought, but imagine that a person has grown up their whole life on Molokai, and their family lives there, too, and it comes time for them to be taken care of in their old age, and they have to move islands, they have to leave their home because there is not the coverage available to be helpful to them if they are needy, and their family has to fly back and forth. That is not something we want to sanction.

We want to take the best of these two bills. We want to take the best of these bills on prescription drug coverage. We want to take the best of these bills on not cutting our hospital payments, and that is what this motion says.

This motion which has been brought three times now before this House by

my colleagues, and I now bring it here today, simply says let us not talk anymore, let us do it. Let us take the best of these bills that we know will do the job, and let us adopt them in conference because we have the ingredients, right now, to do a good job for rural America. The question is will we do that job for rural America?

So this bill simply says, on prescription drug coverage, let us have a fall-back option. If there is no prescription drug coverage available under Medicare in our rural communities, then there is a fall-back provision on prescription drug coverage, not by the private sector, but by our government.

This motion says let us take the best of both the House and the Senate versions on reimbursing our providers. If we cannot provide basic services in our communities to those in need, there is something wrong, and we need to provide for the adequate reimbursements, and this bill says let us do that, and this bill also says that we need our hospitals, our critical access facilities in our rural areas. We need access in our rural areas.

Again, the example of Hawaii, a State that is an island State, where one cannot simply get to the urban center of Honolulu easily, where people are spending, like I said, thousands of dollars just on transportation needs because these are not available in their districts whether they be Kauai or Molokai or Maui or the Big Island, that we will provide the necessary payments to our hospitals to keep them open at a basic level of service for our rural areas. That is what this motion says, and I think it is pretty simple. It is a matter of priorities.

If our priorities are to ensure the health of our rural economies, our rural lifestyle, which is the heart land not only of our country but of our thinking, of our culture, then we need to protect these rural communities, and health care is the way to protect them.

So let us not avoid this anymore. Let us just vote on this motion, let us give our conferees direct instructions that we collectively care about rural health care and that we intend to follow through and that we will put our money where our mouth is.

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

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

Mr. Speaker, the gentleman makes a very good case for rural health care, and I commend him for that and because we have heard the same case made time and time again, and this is why we have provided an approximately \$25 billion increase in payments to rural providers.

Before I go into that, I would advise the gentleman through the Chair, if I may, that I certainly agree with him regarding wellness, preventive health care and whatnot, and for something like 60 years or 30 years after Medicare was devised, we did not have, in Medicare, provisions for preventive health

care. And it was not until a few years ago, in the 1990s, in the late 1990s, when finally a group of us got together on a bipartisan basis and finally for the first time put some preventive health care coverage reimbursement, if you will, in order to cover those areas.

In the House bill, in the House bill, the gentleman has not referred to this, we have a provision to the effect that when a person is about to go under Medicare, there is a reimbursement coverage. In other words, provided payment by Medicare, for a one-time physical. It is a voluntary type of a thing, but a one-time physical to encourage people to take that physical before they go into Medicare, and with the idea, of course, that many problems, many illnesses, prospective illnesses might be picked up at a real early stage and thus save not only an awful lot of money, of course, to the taxpayer ultimately, but certainly save an awful lot of money and inconvenience and pain for the beneficiary.

This is what is in the House bill, as I understand it. It is not the Senate bill. It is one of those provisions that we, on the Member level in conference, are going to have to address. The American Cancer Society supports that provision, and it is my idea, and so, certainly, I support it. So I agree with the gentleman about preventive health care, and it is something we are trying to do.

This is, as the gentleman indicated, the fourth time the minority has offered this motion to instruct conferees. I do find it perplexing that they continue to offer this motion, and for one reason only, and that is because by definition, by definition, it would reduce the amount of funding available for the new Medicare prescription drug benefit by 10s of billions of dollars.

So, yes, do we want to increase and are we, in fact, increasing the reimbursements to rural Medicare providers? Yes, we are doing that. If we increase that amount, we are taking it from where? We are taking it, of course, from the prescription drug benefits available to seniors.

The author would have the Medicare conferees accept every rural provider increase contained in both bills, as he indicated. I would note for my colleagues, and I have already said this, that the House has already recognized the need to ensure the rural Medicare providers are paid fairly. In fact, the House-passed bill contains a \$24.9 billion increase in payments to rural providers, which will help rural hospitals and physicians, among others, continue to provide care to rural Americans. So, if the House bill goes down, or if we do not have a bill, let us say both bills go down because we want perfection, the rural hospitals will lose \$25 billion as a result of that decision.

Since the authors of this motion continue to emphasize that their motion will not cause us to exceed the \$400 billion laid out in the budget resolution, we would have to reallocate funds, I

have already said it, away from beneficiaries and towards whom? Towards rural providers.

□ 1300

Would we like to do that? Yes. Would we like to take it away from prescription drug benefits? The answer is no. I do not support it. I think the House bill strikes the right balance between providing a meaningful prescription drug benefit and helping ensure that providers, especially those in rural areas, continue to serve Medicare beneficiaries.

This motion would also, in some cases, require a type of government-run fallback. Although the House passed legislation, both bills have a fallback. The House passed legislation has a fallback. It already guarantees that every Medicare beneficiary will have a choice of the least two Medicare prescription drug plans.

In fact, the Congressional Budget Office tells us, and they are, of course, as bipartisan as you can be, that under both acts, CBO estimates that all Medicare beneficiaries would have access to prescription drug coverage. In spite of that, both bills have a fallback. They are good fallbacks. As time goes on, if, God forbid, we might have to fall back, if you will, to a fallback, and it looks like it is not working, then, of course, that is something that can be adjusted. But there really is not that much of a difference in terms of what the fallbacks are as I understand it. It is just the case of the Senate bill fallback would immediately fall back to the government picking up 100 percent of risk whereas the House bill affords flexibility, if you will, from the standpoint that one fallback may result in government picking up a certain percentage of risk in some areas and in some other areas and pick up a larger risk or smaller risk or something of that nature.

We have found that, in order to control costs, it is important that Medicare prescription drug sponsors share some of the risk associated with providing this new benefit. I am uncomfortable asking the Federal taxpayer to completely shoulder the weight of this new entitlement. That is why I do not think we need the government running prescription drug plans. But the fact of the matter is the fallback is there, and there is a guarantee in the House bill that a plan will be available for all beneficiaries.

And, finally, the motion instructs conferees to recede to the Senate and remove the hospital market-basket update adjustment contained in the House bill. I would note for my colleagues that we are not cutting hospital reimbursement. We are not cutting hospital reimbursement. We have hospitals all over, whether it be urban areas or rural areas, my area is somewhat in between, if you will, but we are not getting hospital reimbursements.

According to the Medicare Payment Advisory Commission, which we call

MedPAC, it is the nonpartisan panel of experts that advises Congress on Medicare policy, hospitals currently make a 10 percent profit for Medicare inpatient services and a 5 percent profit, on average, for all services provided to Medicare patients.

So I have already emphasized, if you will, MedPAC unanimously advised Congress to increase payments by 3 percent, which is what the House bill does. We have gone along with basically the experts in that regard, MedPAC.

The \$25 billion approximate increase in provider payments in rural areas is based on certain formulas. Iowa hospitals would receive a certain percentage, Hawaii hospitals receive a certain percentage, increases above and beyond that 3 percent I might add.

Additionally, and it has not been mentioned in the motion to instruct, but under the current law, Medicare providers would have reduced their reimbursement by 4.4 percent. The House bill increases that by 1.5 percent. You are talking about a swing of 5.9 percent to Medicare providers, M.D.-type providers, if you will, which would take place if we enact this legislation into law. If we defeat this legislation and defeat any version of this type of legislation, those providers would be hurting. The rural providers would be hurting considerably more than they are now. And obviously, the beneficiaries, to whom we have promised prescription drugs of a sort, would be hurting.

Mr. Speaker, given the progress the conferees have made toward reaching an agreement, progress is being made, it is slow, there is no question about it, but it is moving, I would hope that conferees are given the opportunity to work through their differences between both bills. After all, that is what the system is all about. There are differences between the House version and the Senate version. And conferees were appointed on a bipartisan basis in order to try to work out those differences.

Basically what we are saying to the gentleman and to the entire House is give the conferees the opportunity to work, and hopefully we will be able to successfully address the many competing issues in a satisfactory way.

And more importantly, in addition to helping the rural providers and rural hospitals, all providers, et cetera, we will be providing our seniors with a prescription drug benefit that they need so very desperately.

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

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

Mr. Speaker, before yielding to my colleagues, I would simply note that as to the last comment made by the gentleman from Florida (Mr. BILIRAKIS) on the bipartisan nature of this conference, I think it is well known within this Congress, and I hope that it is well known outside of this Chamber, that the minority party is not particularly participating in that conference and is

not particularly being consulted. And as a result, we are certainly willing and able to do that in the full glare of publicity before the whole country.

Mr. Speaker, I yield 4 minutes to the gentleman from Arkansas (Mr. BERRY), a person who understands rural communities, understands rural concerns. He lives them.

Mr. BERRY. Mr. Speaker, I want to thank the gentleman from Hawaii (Mr. CASE) for his leadership in this matter. And I can say that I know that my distinguished colleague, the gentleman from Florida (Mr. BILIRAKIS), cares about senior citizens and their health. I know that there are many Members on both sides of the aisle that have a genuine concern about what happens to our health care system and what happens to our senior citizens. But I have to tell you, Mr. Speaker, as we consider H.R. 1, and just as my distinguished colleague, the gentleman from Hawaii (Mr. CASE), just mentioned, every meeting of the conference committee does not include the Democrats. I do not know why that is, but that is the way it works around here.

I would probably call this H.R. 1 bill that we are working with right now, I would be more inclined to call it a fallback or a fall-off or fell-off or jump-off or some characterization like that because this bill just simply does not provide any kind of a guarantee for our senior citizens as to what it will do or a guarantee to our health care industry as to what they need to see in the way of the ability to continue to provide services and do business.

And, certainly, in rural America there are no guarantees. We lose hospitals almost on a monthly basis across this country in rural America. We have providers now that just simply do not take Medicare patients any more. Most of this is as a result of the Balanced Budget Act of 1997, which I proudly voted against; and it has put our health care system in great jeopardy.

Now we are talking about another Medicare reform bill that would reduce payments in some cases to all hospitals, and certainly it would make it more difficult for our rural hospitals and rural providers to stay in business, and it does not guarantee any kind of a prescription drug benefit to our rural seniors who would need it the most.

So I would encourage my colleagues to look carefully at this and not do something that will hurt rural America and our seniors. It is very disappointing to think that the possibility even exists that we would not have a fallback provision that would ensure that our seniors in rural communities would have access to a Medicare prescription drug benefit.

Over the last 25 years, over 470 rural hospitals have closed. Rural hospitals all over the country are in danger of being forced to shut their doors. Currently, hospitals receive full inflation market-basket payments for inpatient and outpatient services. H.R. 1 would reduce hospital payment updates for

the next 3 years, costing hospitals an estimated \$12 billion.

Our health care system in this country is on the verge of serious, serious problems. All we are asking for is a fair deal for rural America and a fair deal for the people that provide the services to our senior citizens through Medicare so they can stay in business.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume to respond to the gentleman, and I appreciate his comments because he is so very much concerned about health care for our seniors; but I mentioned the conference is taking place on a bipartisan basis, and the truth is it is. We have two United States Senators from the other party who are part of that conference, on an everyday basis, I might add.

Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the chairman for yielding me this time and for the opportunity to address this issue.

Mr. Speaker, as previously pointed out, this is the fourth time the minority has offered this motion to instruct Medicare conferees. I personally find it perplexing that they continue to offer this motion, since by definition it would reduce the amount of funding available for the new Medicare prescription drug benefit by tens of billions of dollars. The author of this motion would have the Medicare conferees accept every rural provider increase contained in both bills, both bills.

I would note for my colleagues that the House has already recognized the need to ensure that rural Medicare providers are paid fairly. In fact, the House-passed bill contains, as was previously pointed out by the chairman, almost \$25 billion in increased payments to rural providers; and that will help rural hospitals and rural physicians continue to provide care to rural Americans.

Since the authors of this motion continue to emphasize that their motion would not cause us to exceed the \$400 billion laid out in the budget resolution, they would have to radically reallocate funds laid out by the House bill in a manner that would disrupt the delicate balance laid out by the bill. The House bill strikes the right balance between providing a meaningful prescription drug benefit and helping provide incentives that providers, especially those in rural areas, continue to serve Medicare beneficiaries.

This motion would force the Department of Health and Human Services to offer a Medicare prescription drug plan. This is a Big Government fallback that is shortsighted and unneeded. The House-passed legislation guarantees that every Medicare beneficiary will have the choice of at least two Medicare prescription drug plans. In fact, the Congressional Budget Office tells us that under both acts estimates are that all Medicare bene-

ficiaries would have access to prescription drug coverage.

We have found that in order to control costs it is important that Medicare prescription drug plan sponsors share some of the risk associated with providing this new benefit. The taxpayers should not be asked to completely shoulder the weight of this new entitlement, and that is why we do not think we need the government running prescription drug plans.

Finally, the motion instructs conferees to recede to the Senate and remove the hospital market-basket update adjustment contained in the House bill. I want to be very clear about how the House bill approaches the hospital issue. The House bill does not cut hospital reimbursement. According to the Medicare Payment Advisory Commission, hospitals make a 10 percent profit in Medicare inpatient services, and a 5 percent profit on average for services provided to Medicare patients. The Medicare Payment Advisory Commission unanimously advised Congress to increase payments by 3 percent, which is what the House bill does.

Mr. Speaker, I think I also need to add that the gentleman from Arkansas who just spoke said that rural providers need our help. And I would submit that if the other side of the aisle wants to be helpful to rural providers, they would instruct Members of their party in the other body to take up and pass meaningful medical liability reform. A fair justice system would do more to help rural hospitals and rural providers than any other action.

Finally, Mr. Speaker, given the progress the conferees have made toward reaching an agreement, I would hope that the conferees are given the opportunity to continue to work through the differences in both bills. I am confident that we will successfully address many of the competing issues in a satisfactory way. Most importantly, we will provide our seniors with the prescription drug benefit that they so desperately need.

□ 1315

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

I would simply note, with respect to my colleague's comments, the Department of Health and Human Services under the motion would be required to do certain things; that is correct. The Department would be required to provide the reimbursements that are necessary to preserve rural health care through the hospitals.

I would also note that sometimes the Department does need to be required to do things. One of the principal issues on the Medicare Reform Bill remains whether the Department of Health and Human Services should be required to enter into basic bulk purchasing arrangements to lower the cost of prescription drugs. The bill that came out of this House would have prohibited them from doing that; and clearly, in

this instance, the Department needs to be told to do what every American knows is the right thing to do.

Mr. Speaker, I yield 5 minutes to the gentleman from Alabama (Mr. DAVIS) who totally understands rural America.

Mr. DAVIS of Alabama. Mr. Speaker, let me thank my friend and colleague from Hawaii for his passion on this issue and for reminding us that in the United States the face of rural America is not simply Southern or Western, it can even be Pacific at times.

Let me begin, first of all, by saying or by reiterating something that my friend from Arkansas said, I do not think that any of us on this side of the aisle believe that any of our able colleagues on the other side want to do violence to the interests of rural America or do not care about what goes on in the heartland of America or in the rural parts of our country. We are not having a debate about intent today or a debate about goals today, but we are having a debate about making a system that will work.

It is a fact, and it is an eventuality under the bill that the Republican leadership so narrowly pushed through this body, that over a period of time, the prescription drug benefit, that all of us want and have endorsed in some sense, will be phased out and delivered through the private sector in significant parts of our country. Now, that sounds, from a technical standpoint, like a worthy enough aspiration. I have heard my colleagues on the other side defend that kind of a world in terms of the market choices it will open up. I have heard them defend that kind of a world in terms of the choices it will generate for the consumers, for senior consumers.

The reality, as so many of us on this side of the aisle know, is this: We can travel to those places in west Alabama, whole places in the rural parts of our country where you simply do not have a private provider network that is capable or available to carry this burden. So when we are talking about expanding market choices, what a wonderful thing it would be if those market choices would be available all around this country.

Our seniors are looking to us desperately for leadership on this issue. Our seniors are desperately looking to us to give them a benefit, but not just any benefit. They want one that is fair, and one that is workable, and one that is available all around America.

I am genuinely amazed that a lot of our colleagues on the other side of the aisle are willing to have us move into a system where, at best, we can trust the vagaries of the market to provide this benefit for our seniors. I talk as I move around my district to far too many seniors who are having to spend significant chunks of their limited, disposable income on prescription drugs. I run into too many seniors who are having to self-medicate, who are told that they have to take medicine for a cer-

tain number of days, and they chop the pills up to extend the timetable. All Members can cite those stories.

What a tragedy it would be if we had a huge ceremony and a huge fanfare, and the President stood up and said we had passed a prescription drug benefit bill, and then within 6 or 7 years from now, our seniors living in rural America saw what they expected to be a Cadillac turned out to be a much smaller, less efficient and less effective vehicle.

Mr. Speaker, I urge my colleagues to support this motion not because I think the folks on the other side of the aisle have a different set of values, but because I think they misunderstand the market that we have and the choices that will be left to our seniors.

I want to address one other point several of my colleagues make. There has been a lot of talk that we are fixing the rural problem because we are addressing the disparities in the reimbursement formulas; and I compliment the other side of the aisle for recognizing that the reimbursement formulas in Medicare have disadvantaged our rural areas, but I will make a very basic point here. If the Republican leadership of this body were serious about fixing the reimbursement formula, it could do it tomorrow. Just as we came to the floor in record time last week to speak to the court that ruled on the Do-Not-Call Registry, we could come to this floor in record time to pass a stand-alone bill that fixes the unfair reimbursement formulas.

Right now, the reimbursement formula fix is being held hostage to the completion of this bill. It is nothing more than a bargaining chip at this point to try to bring conservative Democrats and moderate Republicans to the table, and we ought to expose that for what it is. If the leadership were serious about fixing this problem, it should be done tomorrow as a stand-alone piece of legislation. Let us address the hard and serious problem of getting a prescription drug benefit, but let us address, in a separate context, the very real problem of disparities in this formula that burden so many of our areas.

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

Just to respond very briefly to the gentleman from Alabama (Mr. DAVIS), this is my 21st year in the House. Virtually all of that time, I have been a member of the Subcommittee on Health, and the question of reimbursements to rural providers has always been there. If it were simple to correct, it could have been corrected. It could have been corrected when the other party was in charge. It could have been corrected when this party has been in charge, which is a lot less years than when the other party was in charge. It is very difficult, but it is being addressed. The conferees are spending a lot of time on that particular issue, and, hopefully, they will reach agreement.

Again, I would say to my colleagues, I have talked to members of the AARP who have come into my office back home. Yes, we have all received a seven-page letter to the effect of what they want in that bill, but they say we want a bill which will help some people now, and, hopefully, provide a foundation we can improve upon as we go on.

If all of us are just going to stand fast and say this is not in the bill or that is not in the bill, or this is in the bill and I do not like it and we want perfection, we are not going to have a bill. As I said before, at least the rural providers are receiving some benefit, some help out of this bill. That \$25 billion is certainly not chicken feed.

It is significant that we have a piece of legislation that is going to be of some help to the rural providers. It may not be enough, it may not be as much as the gentleman would like, and I do not blame him. This is a representative system of government, and they are representing their people, and they are doing a good job of it insofar as wanting to help their rural communities. But again, we have to have a bill, and it is critical that we all try to work together as much as we can.

All of the conferees are not always meeting together in every conference that we have. That is unfortunate, but there are some Members who have indicated that they are against anything at all involving this type of legislation; and, consequently, I suppose those are the reasons. I do not make those decisions, but it is unfortunate. But a lot of work is being done every day at 3 p.m., Monday through Friday, on a bipartisan basis.

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

Mr. CASE. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. BOYD).

Mr. BOYD. Mr. Speaker, I thank the gentleman for bringing this subject to the floor.

I think we all, as Americans, understand this prescription drug issue very well, and I think we understand the importance of Medicare to this Nation. I like to tell my constituents back home that since the advent of Medicare 40 years ago, there has been a significant decline in the level of folks below the level of poverty. Prior to the advent of Medicare, if you reached the age of 65 in this country, there was a greater than 50 percent chance that you would be below the poverty level. Today that figure is less than 10 percent. There is a dramatic drop in poverty in this country, and we think much of that can be credited to the successful Medicare and Social Security programs we have had in place.

I think everybody knows that we need a prescription drug component because of the changes in health care and technology in the last 30 to 40 years. We have to reform the Medicare program. We all understand that. It is absolutely going to break this country as we move into the retirement of the

baby boomers if we do not do something. This Congress, both sides of the aisle, have laid aside \$400 billion to deal with this issue. I want to commend the leaders of this House, including the gentleman from Florida (Mr. BILIRAKIS) for his attempts to reform Medicare and bring those issues to the floor of the House and try to get a bill that we can get the President to sign.

The thing that I want to encourage, though, is that we have got to keep the provisions of the current Medicare system that work. One of the key components of the current Medicare system is that it is a defined benefit. When you reach eligibility age, everybody qualifies for it. I do not care what the situation is, if you live rural America, urban America, you qualify because it is a defined benefit, and everybody receives that. We have some Medicare+Choice-type programs within Medicare now that try to set up HMOs or insurance incentive programs to deliver prescription drugs to folks, and they do not work. They do not work in rural areas. My constituents do not get them because the insurance companies cannot make enough money on them, so they go to the larger communities, the urban communities, the big cities, where they can make money.

Mr. Speaker, I just would encourage us to keep those provisions that work, and one of them is the defined benefit, the fall-back provision which the gentleman from Hawaii (Mr. CASE) is stressing here.

The House bill fails to meet the needs of one-fourth of the Medicare beneficiaries of this country that live in rural areas. The Senate bill addresses this problem by establishing a guaranteed fall-back provision. Again, we need reform, but I would encourage the leadership and the conference committee to include the fall-back provision.

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

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

Mr. Speaker, in closing, this has been a good but all-too-short discussion which has highlighted some of the principal differences between the majority and the minority on the issue of Medicare.

I would like to respond to some of the points made by the gentleman from Florida (Mr. BILIRAKIS). I agree with my colleagues on the minority side that the gentleman from Florida (Mr. BILIRAKIS) does care about Medicare. In fact, he reminds me of a country doctor, nice, calm, reassuring presence. And if I was the majority party, I would want a nice, calm person to stand up and talk about Medicare, and I have no doubt about his sincerity.

But I will say that in terms of the positions which have been taken by his party, the positions that have been advocated by this administration and the positions that are now pending in Congress, actions speak louder than words.

Perception is not reality. We would not be standing here bringing this fourth motion, and we bring this fourth motion because we care about rural America. We care about health care in rural America, and we believe that it is at risk, serious risk right now.

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We want people to know that so that in the 16 days remaining before the largest health care reform initiative in decades, if you want to call it reform, comes up to us for a final yes or no vote, the people of this country can weigh in. That is why we keep on bringing this motion and we will keep on bringing this motion.

I want to highlight some of the things that were said here today. First of all, much has been said about affordability. Affordability is a matter of priorities. Affordability is a matter of where you put your money. You ask any rural hospital, rural clinic, any senior living in rural America where they think that the resources of this country should be devoted and they will tell you health care, and they will be right.

So this is a box that the majority has put itself in. It has decided that there are these limits and that is all that we are going to give to this problem and then we are going to live within these limits.

When we on this side say, those limits are not accurate, those limits are not good, they say, well, you are trying to get out of the box. You bet we are trying to get out of that box. That box does not work for America.

Reforming Medicare is one thing. We all agree that Medicare needs reforming. We all agree that Medicare needs fixing, but reforming it should not be destroying it, and that is what is at risk here.

There are good ingredients in both the House and the Senate versions. All we are asking in this motion is to take the best of both the House and the Senate provisions, homogenize them, do not duplicate them. We are not asking for things to be duplicated and run up; we are saying take the best. Guarantee a prescription drug coverage where the private sector is not going to provide it if, in fact, the effort to privatize Medicare is successful. Make sure that our rural areas have basic hospitals.

We do not want a country where everybody has to take a train, plane, boat or other means of transportation to get to some big city that has some big hospital. That is not the answer to health care in this country. That is what we care about.

I would close by saying again that this motion, this issue, is not just about Medicare. It is not just about health care. It is not just about seniors. It is about rural America. And when it is about rural America, it is about the America that we live in and that we want to preserve.

I urge my colleagues to support this motion. It is a simple motion. Just

take the best. Do what is necessary for rural America. Put rural America first.

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

The SPEAKER pro tempore (Mr. BASS). All time has expired.

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 Hawaii (Mr. CASE).

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

Mr. CASE. 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 and the Chair's prior announcement, further proceedings on this motion will be postponed.

MOTION TO INSTRUCT CONFEREES ON H.R. 1308, TAX RELIEF, SIMPLIFICATION, AND EQUITY ACT OF 2003

Mr. DAVIS of Alabama. Mr. Speaker, I offer a motion to instruct.

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

The Clerk read as follows:

Mr. DAVIS of Alabama, moves that the managers on the part of the House in the conference on the disagreeing votes of the two Houses on the House amendment to the Senate amendment to H.R. 1308 be instructed as follows:

1. The House conferees shall be instructed to include in the conference report the provision of the Senate amendment (not included in the House amendment) that provides immediate payments to taxpayers receiving an additional credit by reason of the bill in the same manner as other taxpayers were entitled to immediate payments under the Jobs and Growth Tax Relief Reconciliation Act of 2003.

2. The House conferees shall be instructed to include in the conference report the provision of the Senate amendment (not included in the House amendment) that provides families of military personnel serving in Iraq, Afghanistan, and other combat zones a child credit based on the earnings of the individuals serving in the combat zone.

3. The House conferees shall be instructed to include in the conference report all of the other provisions of the Senate amendment and shall not report back a conference report that includes additional tax benefits not offset by other provisions.

4. To the maximum extent possible within the scope of conference, the House conferees shall be instructed to include in the conference report other tax benefits for military personnel and the families of the astronauts who died in the Columbia disaster.

5. The House conferees shall, as soon as practicable after the adoption of this motion, meet in open session with the Senate conferees and the House conferees shall file a conference report consistent with the preceding provisions of this instruction, not later than the second legislative day after adoption of this motion.

Mr. DAVIS of Alabama (during the reading). Mr. Speaker, I ask unanimous