use this for a tax cut, then they would have supported some of the amendments that we made in the Committee on Commerce and also tried to get included in the Committee on Rules that would have not allowed the savings to be scored for budgetary purposes.

We had such an amendment in the Committee on Commerce, and again, it was defeated along partisan lines with the Republicans voting against it, because they do, indeed, intend to score these Medicare savings of $270 billion to pay for the $245 billion in tax cuts. Those tax cuts, again, will go mostly to wealthy Americans and other corporations.

Mr. Speaker, I think it is a very tragic day for America's seniors that this Medicare bill was passed, and that the Democrat substitute was defeated, but hopefully, there will be more debate, if not here, then certainly in America as a whole over the next few weeks and the next few months to bring to light how terrible and devastating this bill, this Republican bill is, and that we will eventually see changes so that it does ultimately make it possible to continue to have a quality health care program for the poor senior citizens in this country.

NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,

October 18, 1995.

Hon. NEWT GINGRICH,
Speaker of the House, The Capitol, Washington, DC.

DEAR MR. SPEAKER: On behalf of the National Conference of State Legislatures (NCSL), and the Special Committee on Health Care Reform of the National Association of Insurance Commissioners (NAIC), we are writing to express serious concerns about provisions in the House Medicare reform legislation currently under consideration. In particular, we urge you to reconsider provisions in the bill that exempt provider-based organizations (sometimes called provider-sponsored organizations (PSOs) or provider-sponsored networks (PSNs)) from the requirements of state regulation.

The proposal presents significant problems for the states and the current privately-based health insurance market in two fundamental respects. First, consumers could be harmed greatly by the loss of state-level protections resulting from the bill. Secondly, the proposal could eviscerate state regulation of health insurance overall.

By preempting state laws that otherwise apply to PSOs, in one fell swoop, the proposed legislation completely blocks the application of state insurance laws to these entities. These laws currently include financial and market conduct requirements, as well as other consumer protections, for many types of health plans which are similar to, if not identical in form and operation to, PSOs. Thus, state requirements—which have worked effectively for a substantial period of time—would be entirely eradicated for a growing and substantial segment of the health insurance market.

In order for the federal government to begin to provide the consumer protections deserved by all health care recipients, it must create a bigger and better Health Care Financing Administration to oversee these new organizations. This would result in bifurcated and potentially duplicative state and federal regulatory system. Further, consumers currently benefit from the necessary protections within current state law. It is highly unlikely that the proposed federal regulatory structure would come close to providing elderly consumers with the ability to lodge complaints currently available for enrollees in state licensed plans. Most significant of all, it is unlikely that a new federal bureaucracy could deal effectively with solvency problems, thus leaving the financial stability of the entire system at risk.

Contrary to the assertions of some, the requirements in state law are not a stumbling block to market innovation. Many provider-sponsored entities already operate and compete under the existing state regulatory structure. We question the viability and quality of those entities which could not withstand the test of state regulation.

Second, it is perplexing that the 104th Congress, which is to be commended for championing the states in so many respects, would intrude in this instance on states' rights—particularly in an area where the states clearly have superior expertise and experience: insurance regulation. The proposed legislation exempts association plans, as well as PSOs, from state regulation. Presently, both types of entities are largely subject to state law.

You must recognize the threat to the state insurance regulatory mechanism that this provision in the reform legislation presents. The proposed uneven regulatory playing field where PSOs are subject to different, and possibly less stringent, requirements is a discriminatory system. Once created, it will not be easily stopped. Every other type of organization in the health care delivery system will want the same treatment. Importantly, under the terms and definitions of the bill, this will be easy. All entities will reconfigure themselves or form subsidiaries to become PSOs. We urge you to avoid this prospect that could lead to the effective federalization of health insurance regulation.

In summary, we strongly object to any provisions in Medicare reform legislation which exempt PSOs from state regulatory authority. All Medicare beneficiaries deserve the same protections afforded other citizens of the states. The erosion of traditional state authority contained in the proposal is simply not justified and could worsen, rather than improve, the health care system.

Thank you for your consideration. Please contact us if you have any questions.

Sincerely,

BILL POUND,
Executive Director, NCSL.
LEE DOUGLAS,
President, NAIC and Chair, Special Committee on Health Care Reform, Commissioner of Insurance, State of Arkansas.

REPUBLICANS PRESERVE MEDICARE FOR GENERATIONS TO COME

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Illinois [Mr. HASTERT] is recognized for 60 minutes as the designee of the majority leader.

Mr. HASTERT. Mr. Speaker, I thought we would take some time this evening to talk about the bill that we passed today, the Medicare bill where the Republican proposal to save and preserve Medicare for generations to come was passed in this House.

It was interesting to listen to some of the previous speakers and some of the shameless rhetoric that we have heard through the last hour or so about some of the proposals that were supposedly proposed in the Medicare bill, and in the next hour I would like to talk about some of those fallacies that were presented here and talk about why Republicans decided that we had to look at a system that has been in place for 25 years, or actually 30 years, since 1965.

Mr. Speaker, what happened last April, the President's Board of Trustees for Medicare came forward and said that Medicare is going to go broke, that we start going into arrears next year, in fiscal year 1996, and by the year 2003 or 2004 Medicare would be totally bankrupt. So we had a choice. Basically, Democrats and others today had a choice in this Chamber. You could vote for a program that was going to save Medicare, preserve Medicare and give seniors choices, or you could vote no and let Medicare go bankrupt so there would be no Medicare system in the next year or 2 years or 7 years, and let seniors down, take away a promise that has been there for a number of years.

In developing the Medicare plan that we had before us today, I would just like to take a minute and say that I think we went beyond the traditional square of how politicians think. We brought in health care recipients, organizations like AARP and other consumer organizations for seniors. We brought in management, risk managers of the Fortune 500 companies, we brought in hospital folks, we brought in nursing home folks, we brought in doctors and other providers to listen to what their problems were and how to design a Medicare system for the future.

We asked people to do one thing, and that was to think beyond either cutting down the benefits that have always been there to squeeze down the dollars that we spend on Medicare and hold back those benefits, or hold back the dollars that the providers got, or those types of traditional ways that the previous leadership in this House has behaved towards Medicare, or to try to think beyond the traditional square. How do you create a new system, how do you create a Medicare system that will reach into the future that will give people better services, better choices, and be a system that really starts to move towards the private sector?

Well, we decided that the fee-for-service system that has always been the traditional Medicare delivery system in this country was near and dear to many people. We did not want to upset seniors, and we wanted to make sure that that system was always there if people chose to take it. Also then, we wanted to offer an array of choices, and those choices, one of them is about 10 percent of our seniors in Medicare today already take the choice of managed care, or what we call HMO's, or Health Maintenance Organizations.

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Along with that, they do not have those choices today, but PPO's are also part of that choice system. In this system, a health maintenance organization may offer somebody prescription drug benefits, prepaid, and they offer to do away with copayments and they even offer to pick up part B premiums. So there is a real incentive to give people a better product at a lower price. Of course, that is the real market system starting to develop.

People also might want to develop what we call a provider service organization, where doctors and hospitals get together and offer a new system to health care recipients, to the Medicare recipients in this country. Of course, people may want to go to a medical savings account that we are going to talk about here tonight, where people can make choices of where they want to keep their traditional doctor, what kind of health care they want to buy, and if they do not spend a prescribed amount of money they get to keep it. That is certainly a unique idea in this country, especially when you deal with huge bureaucracies that formerly controlled the health care in this country.

Then, finally, the seamless coverage, that if you have had a health care insurance system where you worked for the last 30 years, you liked that system but all of a sudden you are reaching 65 years of age and, my gosh, you have to give up the insurance you have always known and try to find some other kind of a fee-for-service system in the Medicare system, that is a very traumatic experience to some folks. If your insurance company has agreed to stay within the system, now you can have that seamless coverage and stay with that traditional insurance that you have always had.

Those are the choices. But some of the things we want to talk about here tonight, talk about some of the fallacies that one friends on the other side of the aisle have brought up but also some of the positive things about those positive choices that people will enjoy and at the same time trying to squeeze out the fraud and abuse that we have in health care. We think up to 10 to 15 percent of the dollars that we spend in Medicare today are wasted in fraud and abuse under the present system. We need to change that. We have brought in tough new provisions to make that happen.

I would like to defer, first of all, to my friend, the gentleman from Connecticut [Mr. SHAYS], who has also been on the ground floor of putting this program together; and we are going to talk about the inception of the change, the new system of Medicare. Plus we have with us the gentleman from New Mexico [Mr. SCHIFF] and the gentleman from Oklahoma [Mr. COBURN]. It will be interesting to hear from these gentlemen as well.

Mr. SHAYS. I thank the gentleman for yielding and want to say that I have seen our conference work on this legislation for well over a year, because we started, in fact, when we were in the minority to deal with this very serious problem of reforming our health care system and making it a better system for all.

One of the first fallacies, and there are going to be a lot of fallacies that we have to deal with, is this whole concept that we are in fact cutting Medicare. You can look at it in three different ways. Each way it is a significant increase.

In the last 7 years, we spent $926 billion on Medicare. We expect to spend in the next 7 years $1.6 trillion. It is about a $675 billion increase in new money over the next 7 years. We are going to spend 73 percent more money in the next 7 years than we spent in the last 7 years. Only in this place, in Congress and in Washington, when you spend 73 percent more during the next 7 years do people call it a cut.

We could look at it in terms of how much we spend today on Medicare. We spend $178 billion. In the 7th year we are going to spend $274 billion, estimated. That is a 54 percent increase in the 7th year. So we are going to spend in the 7th year 54 percent more than we spend today. Only in Washington when you spend 54 percent more would people call it a cut.

But then people said, Well, wait a second. There are a lot more beneficiaries. So we said, Yeah, let us see the impact on each individual beneficiary. We put aside for every senior approximately $4,800 per beneficiary, per senior. In the 7th year, that is going to go up to $6,700. That is a 40 percent increase per beneficiary in the kind of money we are putting into the system.

Mr. HASTERT. So what the Democrats are saying, that we are cutting Medicare, actually, we are expanding Medicare 40 percent over the next 7 years, is that correct?

Mr. SHAYS. Per beneficiary. We are putting in 73 percent more money in the next 7 years over the past 7 years. We are spending 54 percent more in the 7th year than we are spending today. Any way you look at it, we are spending a colossal amount of increased funds in this program.

Mr. SCHIFF. If the gentleman would yield on the same point, I want to say that I voted against the tax cut when it was first proposed; and I did not vote against it because I do not agree with tax cuts. I did not buy the class warfare argument being offered by the other side. I do not believe the proposed tax cuts go primarily to the rich; and, in any event, I think people keeping the money they have earned is desirable.

I voted against it for one major reason. That is, that I simply felt that we should concentrate on deficit reduction first. I make that point because the argument that is being made from the other side is that everything we are doing is simply for a tax cut and a tax cut for the wealthy. Therefore, I think I am in a credible position to talk about that since I personally did not vote for the tax cut.

It is important to emphasize on the gentleman from Connecticut's use of the word cuts in explaining that, that our colleagues on the Democratic side are using the word cuts or have used the word cuts to mean spending less than a projected increase, even though you are still spending more.

Only in Washington, of course, is spending more called a cut. But here is what I want to emphasize. The original position of many of our colleagues on the Democratic side was that nothing needs to be done with Medicare, everything is fine, everything the Republicans are proposing is simply to fund a tax cut for the wealthy.

Now, this morning they changed that position. This morning, or this afternoon, I guess I should say, in their substitute that they offered here they are proposing to cut Medicare using the word cut as they use it. They themselves have proposed spending less than certain target figures that have existed in government projections.

Why would they propose cutting Medicare unless they now acknowledge there is a real problem here, that Medicare faces bankruptcy unless action is taken? That is something that they have largely denied through the past several months.

Mr. SHAYS. If the gentleman would yield, the President came in with this 10-year plan. In this 10-year plan, he said we needed to reduce the growth, which is the proper term, of Medicare, $127 billion. And what he did not acknowledge, though, that was scored by OMB. The President, in fact, I just want to add weight to it, was suggesting by reducing $190 billion the growth in Medicare.

Mr. SCHIFF. I wanted to make the point that on the House floor today the Democratic counterproposal called for a cut in Medicare as they have used the term cut for the last number of months, spending an increase but not as much of an increase as projected targets. I thinks that that is an important concession that Medicare indeed is in serious projected financial trouble, and somebody had to come forward and start taking the lead on this.

I am going to yield back to the gentleman, but at some point I would like to analyze their current argument which is the difference is now to fund a tax cut.

Mr. HASTERT. If the gentleman would yield, one of the interesting things when they are talking about a $270 billion cut, what they are talking about is they want the inflationary rate of over 10.5 percent to go on unfettered. Our good Democrat friends on the other side of the aisle, who just got done speaking, are saying, let us not try to hold in inflation. Of course, we know what inflation does, especially to seniors. But they want that inflation to go at 10.5 percent. That is how they get to $270 billion more spending.

Mr. SCHIFF. If the gentleman would yield for one moment, and I will not belabor this, but I want to make the point that, of course, more spending is not a cut. But to the extent that some of our colleagues on the other side have said we are cutting Medicare, they proposed today to cut Medicare, too. That is a concession that there really are Medicare problems that we have to address.

They now say, well, the difference between our cut and your cut would fund the tax reduction for the wealthy. That is not true, either. I hope to address that when I get the floor again.

I yield to the gentleman from Oklahoma [Mr. COBURN].

Mr. COBURN. I heard a wonderful example on how to explain this. I have three grown daughters. But I did have teenage daughters. If I gave one of them $20 a week allowance and we come to negotiate again the next year and she wants $40 a week and I say I will give you $25, then she comes to tell me that I have given her a cut? No, I have given her a $5 increase. When you put it in the terms, it is what it would be versus what it should be.

I want to go back to the real point of why we are doing what we need to do. We are not getting value for our dollars in Medicare today. If we are going to assume a 10.5-percent growth, then we are going to assume that we are going to continue to not get value for our dollars.

So we have to ask the question, do we have an obligation to the seniors that are on Medicare today, to those of us that are working, paying for Medicare through our payroll deductions and to the children that are going to have to pay for it in the future to get the best value for every dollar that we spend? If you look at this plan, that is an attempt to move in that direction.

We are giving an allowance. It is going up. It is not going up as much as it has in the past in terms of inflation.

Mr. SHAYS. Thank goodness it is not going up as much

Mr. HASTERT. It is interesting. When we talk about growing Medicare, and the gentleman from Connecticut [Mr. SHAYS] talked about how much more dollars that we are going to put in the system over the next seven years, we base that at about 5.5 percent, which is even less than what the private sector medical growth has been.

When you look at the rate of inflation that the Federal Employees Benefit Plan has had across the country, they have had an average under 5 percent in the last couple of years. We are giving the people the benefit of the doubt, and we are letting Medicare grow at about 5.5 to 6.3 percent.

But the amazing thing is when we say that, no, we are not going to hold in inflation completely, that we are going to let it go, our friends on the other side have said, ''Well, we will let it go, we will let inflation go up to 10 or 15 percent.'' That is where they get the $270 billion. That is wasted money. That is inflation. That is money that never was, never will be, but people would have to pay extra out of their pockets and not get any more in return.

Mr. COBURN. If the gentleman would yield, I think one other critical point, is it morally right to allow Medicare to grow faster than what it should, to be more inefficient than what we can make it? It is morally wrong to do that, and we should do everything in our power to make this an efficient system that delivers affordable quality health care with choice for our seniors.

We can do that. But we have to do that by being honest with what the problem is, being honest with what the numbers are, and then carrying that honesty out and say, yeah, we made the hard votes to do the right thing. To do anything else, we would be shirking our responsibility.

Mr. SHAYS. If the gentleman would yield, what we are really going to do is we are going to just take each of the points that were made by our colleagues on the other side of the aisle and just talk about how valid they were, if they had any validity.

I just make this point. Of the $270 billion of savings to the growth, $133 billion are going to go into the Medicare part A trust fund. That is the trust fund that individuals pay in their payroll tax, the 2.9-percent if you are self-employed, 1.45 percent that you pay if you have an employer; and the other $137 billion are going into the Medicare Part B trust fund. That is the fund that funds all the health services.

My colleague just brought up the issue of taxes; and since I serve on the Committee on the Budget, I would just like to respond to this issue and deal with this other issue that somehow they are linked. They are not linked at all.

When the tax cut passed, and this is a plan that I voted for, we paid for it through the fiscal dividend of getting our financial house in order. The Congressional Budget Office said we had a fiscal dividend of $170 billion by immediately getting our financial house in order. We saved the taxpayers $170 billion on unnecessary interest payments and so on.

Mr. HASTERT. If the gentleman would yield, we paid for those tax cuts.

Mr. SHAYS. That is the point I want to make. I want to say that before we even took up Medicare, we paid for each part of those tax cuts. We paid for them in cuts in discretionary spending, in slowing the growth of our entitlement programs that we specified and through our fiscal dividend. So it was paid for through very serious and in some cases difficult votes.

Our logic was, why have a program, for instance, a government program that is supposedly helping a family when 20 to 30 percent get taken off by the bureaucracy before it gets to the family, with all the bureaucratic requirements of the government program, and why not just get that family the money? A major part of it is the $500 tax credit, $500 for each child.

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Mr. HASTERT. Can I ask you a question and then let the gentleman from New Mexico ask, too? The Democrats are saying this is a tax break for the rich. You are saying tax breaks here are for families with children.

Mr. SHAYS. Anybody can just ask themselves, if you have a child that is under 18, you would get a $500 tax credit. If you are listening today and you feel you are rich, then you would qualify under their definition. And the Senate, on this $500 tax credit, has said it should only go, Republicans in the Senate said it should only go to families under $75,000. But 75 percent of all families make less than $75,000.

So the biggest part of our tax cut will go to individuals with families with children. If they have three children, they get $1,500. If they have four, they get $2,000.

I just would love to make this point, if I could. I would like to make the point that when my parents were raising me and my older brothers, they were able to take a deduction in today's dollars off their income of $8,000, and they could reduce their income. My family, in today's dollars, could reduce $32,000 from their income and not pay tax on that $32,000. You have seen what was then equated to today.

And my family, when they were having to, my mom and dad were raising us, they had to pay less than 20 percent in taxes to Federal, State, and local governments. A family today pays approximately 40 percent in Federal, State, and local. So what we are trying to do is focus the bulk of that tax on families and families that need it.

Mr. HASTERT. The other part of the tax cuts for the wealthy that our friends on the other side talk about, and it is somewhat laughable, because part of those tax cuts are for senior citizens who want to work that earn under $30,000 a year and ones who do not have all the income coming in and rents or interest rates or dividends from stocks or people who have to really go out and work for a living and people who have done that their whole life. But if you earn under $30,000, you do not have to pay that extra income tax or that deduction that you get on your Social Security.

Mr. SHAYS. Even taking into account the capital gains exemption, which we have to score as a loss in revenue, which most economists say will actually generate revenue, this is how Democrats equate it to a wealthy man. If you make $40,000 and you have a one-time capital gain of say 100,000 on the sale of a home or something else and you, therefore, have earned $40,000 in income and then you have this capital gains of 100,000, they say, see, you are a wealthy person, you made $140,000. And they put you on that equation of $140,000.

Mr. SCHIFF. I want to stay on the subject of the relation of our Medicare bill to the tax cuts. As I indicated, I did not support the tax cut only because I would like to see some real time history of budget savings rather than go on a plan. But the point is, for the purpose of this debate, on Medicare, I very strongly argue that the accusation made that this is to fund any tax cut for any purpose is simply incorrect.

I would just like to say that we start at the same place now. We have proposed reducing the rate of growth of Medicare, which they have called a cut. They now propose reducing the rate of growth in Medicare, which they call a cut. So we are now heading in the same direction.

They have conceded the fact that Medicare is heading towards insolvency. The argument that we heard for the last hour was the difference between the two figures, the amount of additional reduced growth, which we say is necessary for the long-term fiscal health of Medicare, they say is to fund the tax cut. I want to take a couple moments to say to my colleagues why that is just not true and why in fact the tax cut in the plan is funded in other ways.

In the first place, part A of Medicare, the hospital trust fund, which is the larger portion of Medicare spending, is funded by a payroll tax. That payroll tax is not affected by other taxes. In other words, other taxes can be raised or other taxes can be lowered. The fact of the matter is, the Medicare trust fund has the exact same source of income which is the payroll tax. So nothing we do in lowering or in fact raising taxes elsewhere has anything to do with part A.

Part B of Medicare that deals with funding physician and other services is paid for, approximately 31 percent, by beneficiaries and approximately 69 percent is subsidized by the general treasury. So the argument can be made, well, the tax cut is being funded by reduced spending in part B, because that is general funds.

The problem with that argument is that every Medicare beneficiary knows that part B regularly, I think annually, goes up in cost as the cost of the program goes up.

The current system is projected to raise the part B premiums for beneficiaries for the general fund in the next several years. The President's proposal will raise the contribution of beneficiaries and the general fund for part B in the future.

The point is, as I have seen the figures, the final figures projected to exist in 7 years for part B for beneficiaries are very close together. I think the widest range difference I have seen projected is that the Republican plan will, in seven years, not for seven years but in seven years would be $7 a month higher per beneficiary than the President of the United States. The point is, you do not fund a multibillion dollar tax cut out of a $7 a month difference.

Mr. HASTERT. One of the things that when we looked at our system and what we have tried to do, the rate today is 31.5 percent. And we keep that tax rate in place.

Now, there is a proposal or under law that this would drop to 25 percent. And if it did, indeed, drop to 25 percent, then taxpayers would have to pick up that extra amount and taxpayers would be subsidizing the part B premium about 75 percent. So the other side of the story, as some people use that terminology, our friends on the other side would actually have a tax increase for those people.

Mr. SCHIFF. It is my understanding that explains the difference between the Republican plan and the President's plan. We would keep the subsidy level of part B the same and not increase it out of the Treasury. But the difference is still too small, is still too small for anyone to say that is funding a multibillion dollar tax cut. It is just not correct.

Mr. SHAYS. I just would love to make sure that we just establish the arguments that are being made and whether they are credible.

First, we are not cutting Medicare. We are allowing it to grow significantly per beneficiary over 40 percent a year. The second argument is that somehow the tax cut is related to what we are looking to do to save, strengthen Medicare. There is absolutely no relationship.

The next argument they make is they say we are increasingly co-payments, which simply is not true. Co-payments remain the same. They say we increased deductibles. That simply is not true. The deductible remains the same.

Then their argument is that we increase premiums. We are keeping premiums in fact at 31.5 percent, and 7 years from now they will stay at 31.5 percent. As health care costs grow, that 31.5 percent will cost slightly more as it has during the last 7 years. There has been that growth.

So what gets us into this is the exciting fact that we have an option beyond, you can say, in this fee-for-service program. You are not being forced out. No new co-payment, no new deductible, no increase in premium, no relationship between our effort to slow the growth in spending in the tax cut. In fact, no cut in this program, an increase. And it gets into this extraordinary opportunity we have with Medicare-plus.

Mr. COBURN. I just wanted to add, 7 years ago the part B premium was about $26. And it is $46 and 10 now. It is going to rise. It is going to rise a small amount each year for the next 7 years. But it is still going to stay at 31.5 percent of the total cost for the part B program. I think it is important for people to realize that the rate of rise is not going to be significantly different than what the rate of rise has been in the past.

Mr. SCHIFF. The gentleman has just made an extremely important point, that the part B program has been costing more every year and the amount that beneficiaries pay has gone up every year. What the other side argued was the entire projected increase in the part B premium was a result of the Republican bill and for tax reduction. The point is, the increases are coming anyway. The increases are posed in the President's budget. The difference is very small, and the difference is the result of do you want, in this season, in this time frame of deficits, do we want to be increasing the amount of subsidy from the general Treasury.

Mr. HASTERT. I think one of the most important things that we want to get to and I think we should walk through the choices that people have. traditional fee-for-service and the other choices are there, part of this Medicare Program.

Mr. SHAYS. Is it true that you will be forced to get out of your fee-for-service program?

Mr. HASTERT. Absolutely not. The fee-for-service, we believe that our CBO tells us about 75 percent of seniors will stay in the traditional fee-for-service. We think that there is too good an opportunity out there for seniors and seniors who really look at the opportunities they have will move from fee-for-service.

Mr. SHAYS. But they do not have to.

Mr. HASTERT. It is their choice if they want to.

Mr. COBURN. There is 9 percent already in a managed care option who are very satisfied.

Mr. HASTERT. Nine to ten percent are there and looking at that. When those folks get involved, they have options of getting prescription pharmaceuticals paid for. They get co-payments paid for in many of those plans, and we talked about part B premiums. These options are that the system can even pick up the part B premium for the Medicare recipients. So there are some real pluses there.

Mr. COBURN. Mr. Speaker, one of the advantages that I have had in dealing with Medicare is I am a practicing physician. I continue to practice on the weekends. I know Medicare both from a patient perspective and as well as a provider perspective. It is unique to be able to understand; it is very, very complicated. That is one of the reasons our seniors are so concerned, not only because of the rhetoric but because it is very difficult to understand. As we have changed Medicare, we really are going to give four very simple options.

Mr. HASTERT. I would like the gentleman as a physician and a practitioner, a person who deals with both patients and the system, one of our options is a medical savings account. Why do you not talk about that medical savings account and how that can affect patients and the system itself.

Mr. COBURN. I would be happy to. First of all, I think we need to correct what we heard a minute ago, that there

was a $20,000 deductible. That is not even allowed under this plan. So it is not going to be one of the options, and the information stated was incorrect.

A medical savings account is an account like I presently have as a physician. I have a deductible, and I pay a premium each year for that deductible. It is a high dollar deductible. It is $10,000 for my entire family. I am fortunate enough to be able to have that kind of deductible. I am responsible for the bills in between it.

Under the Medicare Program, we will have deductibles, high deductible medical savings account available, which the Government will place into that account, the average payment for that area to purchase a high deductible policy; and what is left over can be used for medical care for that person for that period of time.

Mr. HASTERT. So basically, let us say that next year the Federal Government, and we are just using numbers generally, but next year the Government will pay 5,000, average payment per person will be about $5000 in the next fiscal year. So a person could buy a $3000 deductible catastrophic health care policy for about $2,000. Then the Government would put the balance of that $3000, the balance of 2000 from 5000 average, into their medical IRA. That money would be there.

They would choose where they want to go for health care. They would choose their doctor, what kind of care they wanted. They would also be pretty responsible then for looking at what the cost of that health care is. They actually would go out and shop because, if they do not spend it, they get to keep it. That is one of the things that would rolL over in that medical IRA account. Then eventually, if they want to use that for long-term care insurance or some other type of health care, they could. But the thing is, it is their money. What a unique situation. All of a sudden, people are protective of those dollars and looking into that when it is their money.

I know we have been joined by one of our colleagues who has been a leader in health care for many, many years here, the gentlewoman from Connecticut.

Mr. SHAYS. The distinguished gentlewoman from Connecticut is an expert on this issue.

Mr. HASTERT. I would like to yield to the gentlewoman at this time.

Mrs. JOHNSON of Connecticut. I thank the gentleman for the opportunity to join him at this special order to discuss the Republicans' approach to reforming Medicare in order to secure for current seniors and to ensure that it is going to be there for future retirees.

I wanted to pick up on what the gentleman is talking about. One of the things that was very distressing about the debate this afternoon was the claims by opponents that we could not fund a premium that would buy a good plan in the market.

When we look at what is really happening out there right now already, the Medicare premium that seniors are paying would buy much more for them than Medicare is giving them. In the Boston area, there were two HMO's. Seniors have the right to choose to join an HMO. Not everybody wants to be in an HMO. If you do not like the staff or the doctors in the HMO, you cannot go outside.

□ 2030

I personally am not high on joining an HMO, but they had two very good HMO's in the market in Boston. One of them was the Harvard Health Plan, and the other was the Fallon Plan. Each of those HMO's had developed quite large senior participation, but they were not growing.

Well, into the market came three new managed-care plans offering not only all Medicare services, but additional services, for a zero premium. That is just the Medicare premium. Now thousands of seniors every month are joining one of these five plans because what did the Harvard plan do? They dropped their premium from $89 a month to $15 a month. What did the other plan do? Its premium was over $50. They dropped their premium to zero. Now the seniors in the Boston area have the choice of four plans, four zero-premium plans, the Harvard $15-a-month plan, and for that they get all Medicare services plus copayments and deductibles plus some other, in some cases, prescription drugs, in some cases preventive-care coverage.

Mr. HASTERT. So you are saying that deductibles, this is something plus. I mean before a traditional fee-for-service health care and Medicare seniors have to pick up a copayment; is that right?

Mrs. JOHNSON of Connecticut. Right.

Mr. HASTERT. They would have to pay, pick up a deductible; is that right?

Mrs. JOHNSON of Connecticut. Right.

Mr. HASTERT. They have to pay for their own prescription drugs; is that right?

Mrs. JOHNSON of Connecticut. Correct.

Mr. HASTERT. And sometimes pay for their own eyeglasses?

Mrs. JOHNSON of Connecticut. Correct.

Mr. HASTERT. And under these programs you are saying that they are more efficient, a better system of delivery, and that the can pick up these costs so seniors really save.

Mrs. JOHNSON of Connecticut. Absolutely. Not only do seniors really save, but they choose these plans, they choose to go to a system that they believe serves their needs better, and they are choosing at such a rapid rate that while Medicare managed care used to be 5 percent of that market, it is now 10 percent

Now what does that tell you about our plan? Some people have been concerned, including some of our colleagues, that if our plan does not save as much as we think it will, we will have to make deeper cuts later on.

Well, our Budget Office thinks that over 7 years only 15 percent more seniors will choose MedicarePlus plans like this. Ten percent are in HMO's now, and they think that, when we offer them all these choices, Medicare-plus plans, medical savings accounts, that only 15 percent more over 7 years will join.

In Boston they have already increased it in 2 years by 5 percent. I mean the Budget Office cannot take into account human choice and human motivation, and so they use old data to make old projections, and then they try to force us to make irrational decisions.

Mr. SHAYS. If the gentlewoman would yield, I would just love to emphasize again because we just continually, I think, need to based on what was said on the other side of the aisle. Any senior who wants to can stay in their traditional fee-for-service and have the same doctors they have presently, and I want to continue to make the point that they are never taken out unless they choose to be transferred to a private plan.

Now I just think there is one cautionary element that we need to make, especially coming from our area. It is probably going to be easier for people in the Boston, and New York, and Miami area to see greater opportunities in private health care plans. I suspect in an area like Oklahoma they may not see all the same ability to get some of those plans because we are dealing with high-cost areas and low-cost areas, and we have not yet fully resolved that issue, but I think we are on the way to doing that.

Mr. HASTERT. The gentleman from Oklahoma, if I could yield to him for a minute, I would like him to talk about that difference and also one of the new innovations we have called provider service organizations.

Mr. COBURN. Thank you. I would like to make one point so that seniors know a provision of this bill is that, if you would decide you wanted to go into an HMO and did not like it for the first 2 years, you can get out any time you want. So what we have also done is increased——

Mrs. JOHNSON of Connecticut. Beyond that, every single year you can get out, every single year you get a new choice, and you can stay in the plan you are in, you can change plans, or you can go back to Medicare, and in every single market there are medigap insurance plans that do not discriminate so you can always go back to that combination of Medicare and medigap if you prefer it.

So this is a totally voluntary choice plan that we are providing, and we do have overwhelming actual experience that shows that the Medicare-plus plans will be able to provide a lot more benefits for the same dollar, and if I could just add one thing before unfortunately I have to catch a plane, it is

that, you know, both for the people who stay in Medicare and for the people who choose MedicarePlus, we are going to increase funding for both the premiums and for the fee-for-service system by $2,000 per recipient in the next 7 years. That is exactly as much as we increased it in the preceding 7 years.

So we are planning a healthy, reasonable, responsible, practical increase in spending in Medicare. We are simply not going to overpay for fraud and abuse. We are not going to overpay for unnecessary care. We are not going to overpay because, if we overpay in Medicare, then people who are working have higher taxes.

Mr. HASTERT. I certainly appreciate the gentlewoman from Connecticut joining us for a few minutes. Your work and contribution to health care reform in this country has been legend, and we certainly appreciate you spending a few minutes with us.

Mrs. JOHNSON of Connecticut. Thank you. It is interesting for the people who are watching to see the gentleman from Illinois [Mr. HASTERT] is a member of the Committee on Commerce, I am a member of the Committee on Ways and Means, two committees that have direct responsibility for Medicare and Medicaid. The gentleman from Oklahoma [Mr. COBURN] is also a member of the Committee on Commerce, but he is a physician. He brings a special perspective. The gentleman from New Mexico [Mr. SCHIFF] is a member of the Committee on the Judiciary. He brings special knowledge of the fraud and abuse problems. And my colleague, the gentleman from Connecticut [Mr. SHAYS], is from the Budget Committee, and he has the responsibility to look at these issues in the context of America's future and how do we get to a balanced budget in 7 years, and he, of course, is on the Health Subcommittee of the Committee on the Budget and, therefore, is a special part of our team.

This is the first time in Congress' history that there has been this level of integrated committee cooperation and action to solve a major problem that we face, and right here amongst the five of us you can see that whole body of the Congress, and how it has come together to think about this problem and produce an answer that we know is going to serve our seniors. So I am proud to have joined you for a few minutes and regret I have to leave.

Mr. HASTERT. I yield to the gentleman from New Mexico [Mr. SCHIFF].

Mr. SCHIFF. Mr. Speaker, I just think it is important to emphasize the main purpose of that last entire discussion. We have been talking about the fact that both parties recognize that we have to reduce the rate of growth of Medicare. If we do not, there will not be a Medicare. The costs would not be sustainable.

What the last discussion has meant is the fact that reducing the rate of growth does not have to mean reducing the level of services, that the projected rate of growth that we are talking about and that we have to avoid assumes that it is business as usual without change year after year, and we can explore ideas that might through alternative approaches, through just competition, reduce the rate of growth and still keep the level of service at at least what it is today.

Mr. HASTERT. I thank the gentleman.

I yield to the gentleman from Oklahoma.

Mr. COBURN. I was going to discuss another one of the options, Medicareplus, and that is the opportunity. Heretofore physicians as groups have not been allowed to get together and offer their services as a group in hopes to lowering the costs and attracting more patients, and one of the options under the Medicare Preservation Act is to allow us in conjunction with inpatient hospital facilities and outpatient hospital facilities to offer a provider services network program where we go and offer our services for a fee which would be paid through the Medicare program where we can vastly expand the benefits and also lower the costs.

Doctors for years were saying, ''Let use compete, let us go in. We'll show you that we can deliver the service.'' And now it is time for the doctors to show that in fact they do that, and I believe that they will. It will allow you to keep your doctor and still go into a Medicare-plus, if that is fact is what you want to do.

Mr. SCHIFF. I believe the gentleman is talking about proposals to relax the antitrust laws as it refers to physicians.

Mr. COBURN. That is true.

Mr. SCHIFF. And as a member of the Committee on the Judiciary, I very much support that.

The fact of the matter is for the system to operate there has to be a balance of competition, and we have seen the rise of HMO's health maintenance organizations, which essentially are conglomerates of offering services from an unified place. Many citizens like HMO's and they enroll in them. Other citizens do not want to enroll in HMO's, but the point is, given their existence, there is now a justification to allow physicians with each other and physicians with hospitals and other health care institutions to unite to offer a group-practice kind of policy to citizens that would compete with HMO's to give the citizens choices on an equal playing field.

So, I very much support that change in the antitrust laws.

Mr. COBURN. I think we might just talk about fraud and abuse for a minute.

Mr. HASTERT. Let us make it perfectly clear for everybody here so we can understand a little bit about our provider service organizations.

For instance, if you had 25 or 30 doctor in a large community, all specialists and general practitioners who you chose of the highest quality that you think are good practitioners of health care, and then you found one of the hospitals that was the best orthopedic hospital and another hospital that maybe is the best cardiac hospital, if you join together to provide those services to seniors, then you can give the seniors the best service at the lowest costs.

Is that the whole idea behind this?

Mr. COBURN. That is right, and do that in a unified package that we would know up front what their costs are, know what to expect, and know that they had quality and service.

Mr. SHAYS. What I think is exciting is that, you know, we are affecting the hospitals and doctors, and we are asking them to deal with lesser payments in some instances, but on the other hand we are also allowing them to compete directly with HMO's, directly with insurance companies, and provide their own organization of health care, and I have heard from so many doctors and hospitals that they feel they can reduce costs significantly and provide extra benefits to attract people into that system, and I think it is very exciting that we are allowing that to happen.

Mr. SCHIFF. If the gentleman would yield for just a moment, the point that our colleague from Oklahoma is making is that under existing antitrust laws physicians talking to each other and talking about joining together in the providing of services and offering joint rates is very restricted under the antitrust laws, but given the fact that the HMO's represent a group kind of practice which do exactly that, it makes very good sense to me to allow other groups to form together to offer their packages and then let the beneficiaries in Medicare, and other patients, make their own selection.

Mr. HASTERT. One of the things that we talked about as well as the choices that seniors have, and we talked about a couple of those choices out here, medical savings accounts, HMO's and PPO's, and then now the provider service organizations that we just got done talking about, we always thought also that there is a huge and historically huge amount of dollars, of Federal tax dollars, that go into Medicare that are wasted because of fraud and abuse. We estimate between 10 and 15 percent. That is a huge amount of money when you are talking about hundreds of billions of dollars.

Now we have two experts here on fraud and abuse, certainly the gentleman from New Mexico [Mr. SCHIFF] from the Committee on the Judiciary who looks at that type of issue all the time, and our friend from Oklahoma is an expert on that, but let us talk, talk to us a little bit about the provisions in this bill and how we start to curtail fraud and abuse.

I am happy to yield to the gentleman.

Mr. COBURN. I think the first thing we do is realize we have a problem, and

every Federal Government agency that has testified before the House Committee on Commerce admitted that we had significant problems. Anywhere from 5 to 15 percent was common, with most saying 10 to 11 percent. We have to ask ourself the question why have we not been able to attack the fraud and abuse that is there. I mean why for the last 15 years have we allowed 10 percent of the dollars for Medicare to go to fraud? I mean it is inexcusable. It is also inexcusable for us to now when we start to change it for the Attorney General's office and the Inspector General's office to say, ''Oh, wait, wait, don't change it,'' because obviously we have not put into effect what we need to put into effect to correct the problem.

□ 2045

Our goal is to eliminate fraud and abuse. The way we do that is to make sure we change the expectation of those who are defrauding and abusing; that we, in fact, will catch them. If we change that expectation, then we will limit greatly the amount of people, and number of people, who attempt to defraud.

That requires two main things: First, you have to clarify the rules; and second, you have to have an aggressive fraud and abuse program. I think this program that is in this bill is a very aggressive program.

Mr. HASTERT. We hear stories all the time, Mr. Speaker, that a senior will get a bill, they usually do not get the bills from Medicare, hospital bills, but when they do get those bills and they look through there and they see that they have been charged a great deal of amount. Some of those dollars are cost-shifting, but actually, of course, the story that is going around the Capitol is the lady who looks at her bill and sees that she has been charged for an autopsy, and obviously, she did not receive the autopsy.

She calls in and says, ''I did not receive this autopsy.'' And the person on the other end of the line says, ''It must have been for your quadruple heart bypass.'' She said, ''I did not receive one of those, either.'' What would a senior do under this bill when he gets into a situation like that?

Mr. COBURN. The program is designed to allow the senior to, first, be involved, to encourage them to report it, and also to benefit, if in fact they benefit——

Mr. HASTERT. How do they benefit?

Mr. COBURN. They benefit in that if the savings, I believe, are above $1,000, they share in the savings. They also benefit because they put on notice providers that are not honorable, that they are going to be caught, and it will not take long for the people who are presently abusing this system to recognize that we are going to have 36 million people out there helping us help them do the right thing.

Mr. HASTERT. Is it not a fact, too, that HCFA, the huge Health Care Financing Agency of the Federal Government, a huge bureaucracy that has grown in the last 40 years here in Washington, they have not been very effective in weeding out fraud and abuse, have they?

Mr. COBURN. No, they have not. I think the important thing, everybody that has a credit card, whether it is a BankAmericard or Visa card, when they use that today their bank knows it tonight. If they use it in Japan, they know it tonight. If they use it in South America, they know it tonight.

Our Medicare computer system, we do not know it and we will never know it if it is between two different divisions. It will never be tracked together, so in fact, we have in the past, through this bureaucracy, not even kept up the pace with 1970's computer knowledge and placement. We have spent the last 9 years trying to get a tracking system that will not be available for 3 or 4 more years.

Mr. HASTERT. That is one of the reasons in this bill, instead of throwing billions of dollars, again, at a huge Federal bureaucracy that is not very effective and certainly not efficient, that we have been going out in the private sector and finding those private CPA's who do a good job, who make a living doing that day in, and day out, and have to produce in order to be part of the system, to go out and do that job in fact also; is that correct?

Mr. COBURN. That is correct.

Mr. SHAYS. If the gentleman will yield, and then I would like to yield to the expert on this very issue, my committee and the Committee on Government Reform and Oversight, the Subcommittee on Human Resources and Intergovernmental Relations, has conducted a number of hearings on health care fraud.

We have learned incredible misuses, finding people who have been kicked out of the system, but they continue to be able to do business with the government. We know of agencies that have been fined $150 million because they have been so crooked, different organizations, but they are still allowed to participate. That is one of the things we are pressing our government to start to put an end to.

More importantly, we are learning the incredible fraud that exists and the failure to really get at it with some strong laws.

One of our efforts has been that the gentleman from New Mexico [Mr. SCHIFF] and I have introduced legislation that was incorporated into our Medicare bill. I thought the gentleman from New Mexico could describe that a bit.

Mr. SCHIFF. If the gentleman will yield, I want to say first, though, Mr. Speaker, that the term ''fraud and abuse'' in this context is used as a broad umbrella for many things. It, of course, includes criminal conduct, which I would like to talk about in a moment, but it includes many other things which might be recorded as inefficiencies. It does not mean there is less of a loss to the system, but the gentleman from Oklahoma [Mr. COBURN] was right on point when he said that the system that Medicare uses just to check billings is antiquated compared to private industry doing the same thing, as I understand it.

In fact, the number one complaint I heard from senior citizens meeting in my district on this subject is many of them would spot something wrong in a bill, a service was listed that was not provided to them, and this may not be fraud in a criminal sense, it could simply be an error in billing, but they would contact the Medicare Program through whichever contractor was administering it and tell them about it, and the contractor would simply say, ''It is not enough to bother about.''

Yet, I heard citizen, after citizen, after citizen, enunciate this kind of problem that they encountered with the system. If we can set up a beneficiary reward program where any kind of overbillings, assume the most accidental and inadvertent, if identified, results in a reward to that beneficiary, then that will force the system to respond.

Mr. SHAYS. I think the gentleman really needs to get into the whole criminal side. We have only about 5 minutes left before we lose our time.

Mr. SCHIFF. Time goes fast, as they say.

I want to say that included in the bill through the Committee on Rules was a provision in the bill that I and the gentleman from Connecticut [Mr. SHAYS] wrote, which contains a number of criminal provisions.

We are talking about, here, that small group, but nevertheless, a group that causes a lot of damage that deliberately and fraudulently overbills the system. The essence of these provisions are to make health care fraud a crime.

Right now health care fraud is not a crime under Federal law. If the U.S. attorneys want to prosecute, they have to prosecute under wire fraud, mail fraud, or any other type of statute. This requires a kind of a circular means of prosecuting.

Included in the bill now, based upon our bill, are provisions that make theft, fraud, kickbacks related to health care, a Federal offense, and further, it does not matter who the provider of the health care is, whether it is a government program or a private insurance company, because that small group that engages in really criminal fraud will defraud anybody. As soon as we can convict them, as soon as we can take them off the street, the better we all are.

Since we are winding down, I will yield to the gentleman from Oklahoma.

Mr. COBURN. Mr. Speaker, first of all, I want to thank the gentleman for the criminal provisions put in there. I also would add that we doubled the money penalties, we put mandatory sanctions on providers so they could

not continue to participate in the Medicare system, and we are trying to straighten out the computer problem as well.

I just want to say, as a practicing physician, although physicians will, in fact, get less money than what they would have, which is a cut, or a slowdown in growth, as we hear from the other side, that to act irresponsibly and not save this program is wrong.

This bill has lots of things that I do not agree with in it in terms of detail, but the underlying bill is a good bill, to do what the American people want done; that is, control the growth and make sure a quality health care program for our seniors that has choice and is affordable is there. I think this bill does it.

I can say to all providers, not just doctors, but hospitals and others, that we will have to work harder to be more efficient, to do the right thing, to be careful and to work in a constructive manner to change the system, to make it more efficient, but we can do it. We owe it to our children and our grandchildren to make sure we do that.

Mr. HASTERT. Just the provisions that you gentlemen put in the bill on fraud and abuse, if you can squeeze $10 billion or $12 billion out of fraud and abuse every year and put that back into health care for seniors, what a positive thing this is, just in that one small aspect.

Mr. SHAYS. That is $50 billion of your 270.

I would love just to weigh in and say that we as a Republican majority have three basic desires to accomplish during the course of the next 2 years: We want to get our financial house in order and balance the budget. We want to save our trust funds, particularly Medicare, and we want to transform the social and corporate welfare state into an opportunity society.

Today, we began that journey very significantly in our effort to save and strengthen and preserve our Medicare trust fund, and we did it by allowing this program to continue to grow. We are going to put $1.6 trillion in in the next 7 years, and spend $73 billion more than in the past 7 years. I will turn to my colleague, if he could just conclude.

Mr. HASTERT. I certainly appreciate my colleagues joining me tonight to talk about this, Mr. Speaker. I think the bottom line is that we have our parents and grandparents, and we want to make sure Medicare is there for them, a good Medicare Program that could go beyond the bounds of what has traditionally been there and give them some choices, but most of all, to give them quality health care and give them the assurance that that health care is going to be there for the rest of their lives.

Then on the other side, we have out children and our grandchildren, that we want to make sure that we are not wasting their dollars. That is why we are cutting that inflationary $270 billion that the Democrats just want to leave there, so that they do not have to pay those extra dollars out of what money they have to earn.

It is estimated that a child that is born today has about $186,000 of debt that he has to work off or she has to work off in her adult lifetime. Let us hold that down. Let us be prudent in how we spend the taxpayers' money.

I think this bill gives seniors choices. It secures health care and Medicare for their decision-making process for the rest of their lifetime, and it establishes and holds firm a principle of Medicare, something that seniors have had in this country for years to come. I certainly appreciate your participation in this special order tonight, and I know that the seniors of this country will join me in thanking you very much.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. MARKEY) to revise and extend their remarks and include extraneous material:)

Mr. MARKEY, for 5 minutes, today.
Mr. WAXMAN, for 5 minutes, today.
Mr. DINGELL, for 5 minutes, today.
Mr. BROWN of Ohio, for 5 minutes, today.
Ms. DELAURO, for 5 minutes, today.
Mr. VENTO, for 5 minutes, today.
Mr. DOGGETT, for 5 minutes, today.
Mr. DEUTSCH, for 5 minutes, today.
Mr. TOWNS, for 5 minutes, today.
Mr. PALLONE, for 60 minutes, today.
Mr. OWENS, for 60 minutes, today.

(The following Members (at the request of Mr. CHRYSLER) to revise and extend their remarks and include extraneous material:)

Mr. RIGGS, for 5 minutes, today.
Mr. HORN, for 5 minutes, on October 19, 20, and 23.
Mr. MCINNIS, for 5 minutes, today.
Mr. WATTS of Oklahoma, for 5 minutes, today.
Mr. GOSS, for 5 minutes, today.
Mr. TAUZIN, for 5 minutes, today.
Mr. DORNAN, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. MARKEY) and to include extraneous matter:)

Mr. LEVIN.
Mr. LAFALCE.
Ms. WOOLSEY.
Mr. JOHNSON of South Dakota.
Mr. KLECZKA.
Mr. HAMILTON.
Mr. STUDDS.
Mr. ROEMER.
Mr. SKELTON in two instances.
Mr. ACKERMAN.
Mr. FAZIO of California.
Mr. MFUME.
Mr. WARD in four instances.
Ms. VELÁZQUEZ.
Mr. BROWN of California.
Mr. LANTOS in two instances.
Mr. MENENDEZ.
Mrs. SCHROEDER.
Mr. REED.
Mr. STOKES.

(The following Members (at the request of Mr. CHRYSLER) and to include extraneous matter:)

Mr. GALLEGLY.
Mr. DUNCAN.
Mrs. ROUKEMA.
Mr. GILMAN in two instances.
Mr. CRAPO.
Mr. BUNNING of Kentucky.
Mr. STUMP.
Mr. SMITH of New Jersey.
Mr. SMITH of Texas.
Mrs. MORELLA.
Mr. BOEHNER.
Mr. ZIMMER.
Mr. PORTMAN.
Mr. CASTLE.
Mrs. VUCANOVICH in two instances.

(The following Members (at the request of Mr. SCHIFF) and to include extraneous matter:)

Mr. ROTH.
Mr. FRELINGHUYSEN.
Mr. MATSUI.
Mr. SKAGGS.
Mr. ALLARD.
Mr. MORAN.
Mr. EDWARDS.
Mr. ABERCROMBI.
Mr. HALL of Ohio.
Mr. VISCLOSKY.
Mr. STENHOLM.
Ms. DANNER.
Mr. MCGINNIS.
Mr. EVANS.
Mr. RICHARDSON.
Mrs. FOWLER.
Mr. ORTON.

SENATE ENROLLED BILLS SIGNED

The SPEAKER announced his signature to enrolled bills of the Senate of the following titles:

S. 268. An act to authorize the collection of fees for expenses for triploid grass carp certification inspections, and for other purposes.

S. 1111. An act to amend title 35, United States Code, with respect to patents on biotechnological processes.

S. 227. An act to amend title 17, United States Code, to provide an exclusive right to perform sound recordings publicly by means of digital transmissions, and for other purposes.

BILLS PRESENTED TO THE PRESIDENT

Mr. THOMAS, from the Committee on House Oversight, reported that that committee did on this day present to the President, for his approval, bills of the House of the following title:

H.R. 1976. An act making appropriations for Agriculture, rural development, Food and Drug Administration, and related agencies programs for the fiscal year ending September 30, 1996, and for other purposes.

ADJOURNMENT

Mr. SHAYS. Mr. Speaker, I move that the House do now adjourn.