even lower. Consumers have been learning about this, and particularly seniors.

In Minnesota and all across the country, particularly where we are closer to the borders, seniors especially are getting on buses, and they are going to Canada to buy their prescription drugs. We have this wide disparity between what we pay and what the rest of the world pays.

The question has to be asked, the people who are supposed to protect us are our own FDA, the Food and Drug Administration. So one might ask, what are they doing to help consumers get lower prices? Well, here is the answer. This is an edited version, but I want to point out a couple of sentences. We do not have the whole letter here, but it is available. Anyone who would like a copy can call my office.

What the FDA is doing to help consumers is they are threatening them. If someone tries to order drugs through a mail order house from the United States, what they get with the order that has been opened is a threatening letter. Let me just read it. It says, ''Dear consumer: This letter is to advise you that the Minneapolis District of the United States Food and Drug Administration has examined a package addressed to you containing drugs which appear to be unapproved for use in the United States.''

Well, Mr. Speaker, that is not true. The vast majority of drugs that are coming via this method are legal drugs in the United States. They are approved by the FDA. They are made in exactly the same plants.

Later it says, ''Because you are taking this medication under the care of a physician and we do not want to cause your medical treatment to be unduly affected, we are releasing this shipment. However,'' and this is the important line, ''future shipments of these or similar drugs may be refused admission.''

Now, if one were a 75-year-old grandmother and they get a threatening letter from the FDA, it is very disconcerting.

Mr. Speaker, I think it is time for Congress to take a serious look at this problem. If we could just simply recover part of the costs, the differentials that we are paying for prescription drugs, we could go a long way to solving the problem of those people who fall through the cracks.

Do not just take my word for it. We just received in our offices a little pamphlet from Blue Cross/Blue Shield. Let me just read from it. It says, ''Spending on prescription drugs rose 84 percent between 1993 and 1998.''

Mr. Speaker, it is time for Congress to say that the FDA should not stand between our consumers and lower drug prices.

The SPEAKER pro tempore (Mr. SHIMKUS). Under a previous order of the House, the gentleman from Illinois (Mr. RUSH) is recognized for 5 minutes.

(Mr. RUSH addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Guam (Mr. UNDERWOOD) is recognized for 5 minutes.

(Mr. UNDERWOOD addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Hawaii (Mrs. MINK) is recognized for 5 minutes.

(Mrs. MINK of Hawaii addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

THE PLUS-CHOICE RELIABILITY ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

Mr. BROWN of Ohio. Mr. Speaker, on January 1, 1999, approximately 400,000 Medicare beneficiaries were dropped unceremoniously by Medicare managed care plans. On January 1 the next year, 2000, 400,000 more were dropped unceremoniously by Medicare managed care plans. We can expect at least that much disruption again on January 1, 2001.

By the way, fly-by-night coverage is just one of the shocks potentially awaiting plus-choice Medicare enrollees. Bait and switch. Supplemental benefits are another.

All of us in this body have heard from Medicare beneficiaries who joined a plus-choice plan to gain access to prescription drug coverage or reduced cost sharing only to have those benefits cut back or stripped out just in time for the new year.

Why is the plus-choice Medicare program failing seniors? Ask the Medicare managed care plans, and they will say it is because the Federal Government is underpaying them. Ask other experts and they will say it is because Medicare managed care plans overestimated their ability to operate more efficiently than traditional Medicare, refused to cross-subsidize between high and low reimbursement areas and underestimated the costs of providing supplemental benefits.

Maybe the truth is in the middle, more likely. The specifics do not matter all that much. Most likely private managed care plans simply cannot serve two masters, the public interest and the corporate bottom line.

Whatever is going on, the most expedient ways of responding to the program's failings are also the most irresponsible if our goal is to act in the best interest of Medicare beneficiaries. We could do nothing. We are pretty good at that here.

Is it fiscally responsible to continue pouring public dollars into plus-choice plans? I would rather my tax dollars help finance health care coverage that is more predictable. Insurance that does not give one peace of mind is not good insurance. In Medicare's case, it is peace of mind for beneficiaries and their families alike. Health care coverage that is about as stable as a house of cards simply does not cut it.

We could always pay managed care plans more, but if we do that without exacting a guarantee that these plans will provide stable benefits and continuous coverage, we are perpetuating the same double standard that protected the Medicare choice plan from the beginning.

Somehow, managed care plans can cost Medicare more than the fee-for-service program; can pick and choose which counties they will serve and which ones they will dump; can attract seniors on the promise of extra benefits, then eliminate those benefits, another cost-cutting strategy unavailable to the fee-for-service program, and still can be touted by many in this institution, including Republican leadership, as the long-term solution for Medicare.

How can Medicare privatization proposals be taken seriously when they feature the same private insurance companies and system that excluded half of all seniors in 1965 and treats them miserably 35 years later in the year 2000? I do not get it. When the traditional Medicare program spends more than expected, they tell us it is because public programs are big, bad and inefficient. When private managed care plans spend more than it is expected, it is because big, bad government was not paying them enough to begin with.

In my view, private managed care plans do not belong in Medicare. They do not belong because they are unwilling; and frankly, they cannot prioritize the welfare of Medicare beneficiaries above the welfare of their business.

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If we commit to paying managed care plans this year, then they will want even more next year. If we ask managed care plans to voluntarily commit to staying put and providing reliable benefits, they will tell us businesses require flexibility, and they do.

But Medicare beneficiaries require consistency, stability, reliability. Private managed care plans cannot put many Medicare beneficiaries first. Yet, that is what Medicare must do in order to serve the public interest. If private Medicare managed care plans cannot serve the public interest, we should not pay them a dime.

But regardless of my personal views on Plus Choice, the reality is, right now, millions of seniors depend on it. Policy makers have an obligation to try to make Plus Choice work. If we cannot make the Plus Choice program work, then we have an obligation to get rid of it.

I am offering legislation today to try to make Plus Choice work. Under the Plus Choice Reliability Act, private

health plans would sign a contract to provide continuous service within a service area for 3 years. Health plans would agree not to terminate this coverage within the service area and would be required not to reduce their benefit package during that time period.

Health plans would receive payments for enrollees equivalent to what Medicare would have spent had the enrollees stayed in-fee-for service, no more, no less.

If we pay private health plans what it would cost fee-for-service to cover these individuals, and if private plans still cannot cover them and provide stable benefits or guarantee continuous coverage, as the fee-for-service program does, then it would be fiscally irresponsible and a breach of the public interest to permit these plans to stay in Medicare. It is as simple as that.

I hope my colleagues will join me in promoting a Medicare Plus Choice option that actually provides continuity and stability, attributes that should be a given under our Medicare program.

STATUS OF HMO REFORM

The SPEAKER pro tempore (Mr. SHIMKUS). Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, I am going to talk a little bit about the status of HMO reform before the House and the Senate. I have to admit that I am a little bit disappointed, because I thought that this afternoon or this morning, we would have been debating a bill called H.R. 1304, which is the Quality Health Care Coalition Act. This is the bill of the gentleman from California (Mr. CAMPBELL).

The gentleman from California (Mr. CAMPBELL) has worked on that bill for 3 years. In essence, that bill would allow health professionals to group together to advocate for patient consumer rights without forming a union in negotiating contract provisions with HMOs.

This is pretty important because, in the last 5 or 6 years, there have been over 275 mergers of health plans around the country, leaving us, in this country, with about five or six large HMOs. In many parts of the country, these HMOs, a single HMO may control 50 percent or more of the people who have health care in that area. It is curious that a lot of these, several of these large HMOs do not go into other areas in order to compete with another large HMO.

So what that means, then, is that, if an HMO, for instance, gives a health care provider, a nurse or a pharmacist or a physician, a contract that has a provision in it that is, for instance, a gag rule, a gag clause, where it says one cannot tell a patient all of their treatment options unless one first gets an okay from us.

So, in other words, in my prior life before being a congressman, as a physician, if I had a woman come to me with a lump in her breast, I examined her, talked to her, I would have to say, excuse me, leave the room, get on the phone, tell the HMO I have got this woman here with a breast lump, and ask them if it is okay if I tell this woman all three of her treatment options. I mean, that is an egregious infringement on the right of a patient to know all of the information that he or she needs in order to make a decision.

Yet, there are contract provisions that HMOs have put in physician contracts to that extent. There are other contract provisions that HMOs put into employee contracts where it says that HMO's can define medical care as the cheapest, least expensive care ''as determined by the HMO.''

What would be the problem with that? Let me give my colleagues an example. As a constructive surgeon, I have taken care of a lot of children born with cleft lips and palates. The correct treatment for a kid born with a cleft palate is a surgical repair to close that huge hole in the roof of their mouth so that food does not come out their nose, so they can learn to speak correctly.

But under that HMO's contract provisions where they can define medical necessity as the cheapest, least expensive care, they could say, no, we are not going to authorize routine surgical repair, we are just going to authorize a piece of plastic to shove up into that hole, something called a plastic obturator. It would be like an upper denture.

Now, will the child learn to speak very well with that? No. But it meets that plan's own contractual language of being the cheapest, least expensive care.

Now, let us say that I, as a physician, taking care of children, whose treatment is denied, like this one, decide to get together with other reconstructive surgeons, and we start talking about how this one HMO is routinely denying medically necessary care. We say to each other, I do not think I can renew my contract with that company. Under current U.S. anti-trust law, we could be prosecuted and fined, if not thrown in jail, for being concerned about our patients' concerns.

That was the bill that was supposed to be on the floor. It was a bill that did not, it was not about physicians forming unions, in fact, it would have the opposite effect. It was not a bill about price fixing. It has nothing to do with price fixing. It is a good bill. It had 220 bipartisan cosponsors. We only need 218 votes to pass the House. One would think this would come to the floor.

The gentleman from California (Mr. CAMPBELL) had worked on this for 3 years. Last year, he got a commitment from the Speaker of the House to bring it to the floor last year. Then he got a commitment from the Speaker to bring it onto the floor in January. Then yesterday, before the entire Republican Conference, the Speaker said, yes, this is coming to the floor today.

But a curious thing happened last night. The Committee on Rules was meeting about midnight, they were debating this bill that we should have debated today. All of a sudden, they just tabled the bill indefinitely. So it did not come to the floor today.

I find this very curious because, as everyone in Washington knows, the Committee on Rules functions as the right arm of the Speaker. The Committee on Rules follows the Speaker's will. Some people have said the Committee on Rules is a rubber stamp for the Speaker. In the 5 years I have been in Congress, I cannot remember the Committee on Rules doing an action in committee that has been contrary to the Speaker's will.

Now, yesterday, the Speaker said we were going to have this bill on the floor. He had given his promise to the gentleman from California (Mr. CAMPBELL). Then at midnight, the Committee on Rules tables the measure. Very curious.

Is this the first time the Committee on Rules has disregarded the Speaker's promise? We do not know. It is either that the Committee on Rules, which should function at the Speaker's discretion, did not, that they did not follow their own Speaker's prescription, in which case, the Speaker ought to have a long talk with those Members for not following out his instructions.

Or the other alternative is that they received word from the Speaker, pull the bill. If that is the case, then there is a disparity between what the Speaker promised the gentleman from California (Mr. CAMPBELL) yesterday morning and what happened at midnight.

Most curious. Very unusual. Something in 5 years I have never seen happen here in Congress.

So we are left with the situation that, today, we did not get to debate on a bill that is a free market bill to try to correct HMO abuses.

Last year, last October, when we passed the Bipartisan Consensus Managed Care Reform Act, the Norwood-Dingell-Ganske bill that I helped write, passed this floor with 275 votes, with only 151 against it, last year we heard a lot of people say, I think that we ought to move to HMO reform in a more free market way. We ought to make sure that there is equal playing field so that these types of patient abuses can be addressed in the realm of the free market, in equal negotiations.

Well, we are seeing a situation where we have, in some cases, almost monopolies by large HMOs, squishing any type of concerted action by providers to stick up for their patients. This bill of the gentleman from California (Mr. CAMPBELL) would have gone a long way toward correcting that. Yet, for all those people on both sides of the aisle who voted against the Bipartisan Consensus Managed Care Act, saying I would rather see a free market approach, they do not get a chance today