Reed	Skelton	Towns
Richardson	Spratt	Velazquez
Roemer	Stark	Vento
Rose	Stokes	Visclosky
Roybal-Allard	Studds	Ward
Rush	Stupak	Waters
Sabo	Tanner	Watt (NC)
Sanders	Taylor (MS)	Waxman
Sawyer	Thompson	Williams
Schroeder	Thornton	Woolsey
Schumer	Thurman	Wyden
Scott	Tiahrt	Wynn
Serrano	Torres	Yates
Skaggs	Torricelli	Zimmer

NOT VOTING—12

Chapman	Reynolds	Torkildsen
Houghton	Rivers	Tucker
Linder	Sisisky	Volkmer
Mfume	Tejeda	Wise

□ 1716

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 2275

Mr. MARTINEZ. Mr. Speaker, I ask unanimous consent that my name be removed as a cosponsor from the bill, H.R. 2275.

The SPEAKER pro tempore (Mr. HEFLEY). Is there objection to the request of the gentleman from California?

There was no objection.

APPOINTMENT OF MEMBER TO BRITISH-AMERICAN INTERPARLIAMENTARY GROUP

The SPEAKER pro tempore (Mr. BUNN of Oregon). Without objection, and pursuant to the provisions of section 168(b) of Public Law 102–138, the Chair announces the Speaker's appointment of the following member to the British-American interparliamentary group on the part of the House: The gentleman from Nebraska [Mr. BEREUTER].

There was no objection.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

INTRODUCTION OF H.R. 2350, THE PATIENT CHOICE AND ACCESS ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oklahoma [Mr. COBURN] is recognize for 5 minutes.

Mr. COBURN. Mr. Speaker, as Congress begins its consideration of reforming Medicare, I want to bring to the attention of my colleagues, perhaps the most important component of the Medicare reform debate. What must we do to ensure the quality of care that Medicare patients will receive after changes are made to the program?

While all of us in Congress are deeply concerned about the solvency of the Medicare trust fund, we must be equally concerned that the changes made to this program do not adversely affect the availability of health care to the elderly. As a practicing physician, I have spoken with my patients; and as a Member of Congress, I also have heard from thousands of my constituents. Their message is a clear one. Any Medicare reform proposal must guarantee patient choice and access quality. It must not result in a decline in the quality of care Medicare patients now receive.

For the last several months, I have been working closely with the patient access to Specialty Care Coalition, a group of 115 patient, senior citizen, physician, and nonphysician organizations, dedicated to the principle that patients must be able to access the providers of their own choice. This week, I introduced H.R. 2350, the Patient Choice and Access Act, a bill to provide protection to beneficiaries enrolled in the Medicare Program. Throughout the process of crafting a Medicare reform bill, I have been urging the House leadership to include my patient protection provisions.

The cornerstone of the current Medicare law is choice of health care provider. Presently, there is a belief that the Federal Government can save money by enrolling seniors into managed care deliver systems. And I agree how such changes can produce dramatic Federal savings, I am not opposed to the concept of managed care or a gatekeeper model. Instead, I want to make sure that quality of care for seniors is preserved, should most of the elderly population be moved into managed care. In addition, I have deep concerns about how these proposed changes in Medicare may affect my rural constituents.

Today, many major changes are taking place in the way people purchase health insurance and receive medical care. The pressures to reduce health spending continues to be intense, and health plans and providers have become more aggressive in their cost containment activities. While many health plans have developed a number of effective techniques to achieve economy and maintain quality of care, others have not always achieved that balance. Since Medicare is a federally funded program, we should make sure that these tax dollars are returned to Medicare enrollees in the form of appropriate patient care.

After changes are made to Medicare, many existing and new products will be offered to the Medicare population. Our most vulnerable population will be flung into a fiercely competitive marketplace, where access to appropriated medical services may take a back seat. I believe that in this rapidly changing environment, Medicare patients must be given basic rights and effective protection against the potential that these new markets may inappropriately restrict access to medically necessary health care services.

My legislative proposal addresses these concerns, and it puts the patient first, not the doctor, not the insurance company, but the patient. My bill is designed to improve and enhance health care to our country's senior citizens. It will not add to the cost of the Medicare Program. Under my legislation, all patients will have the option to seek the out-of-network treatment they desire no matter what health care plan they select.

True freedom of choice for patients can only be achieved by making out-of-network medically necessary treatment and services available for all health care plans. Real health care security is the freedom for patients to choose their own primary and specialty care provider, and then to continue to access these same caregivers. All patients should have the option, at an additional copayment known in advance, to seek the out-of-network treatment they desire. This point-of-service feature should be built into every health care plan, and not just offered as an option at the time of enrollment.

Patinets, especially seniors, are acting with less than perfect information about their health status at the time of enrollment. In reality, patients are unable to assess their health care needs, until they actually get sick or need specialty care. Consequently, the broadest possible patient protection is to build choice of health care provider into every health care plan.

The most effective check against abuses in this changing marketplace is the patient's power to go outside the network established by the health plan and obtain medical services. Health plans that provide good service to their enrollees will not be troubled by this requirement. Only health plans that fail to meet the needs of their subscribers will be affected.

Making out-of-network treatment and services available for enrollees in all health care plans provides a very good quality assurance check. It ensures that all health care plans provide seniors with the health care they need and deserve. If a Medicare enrollee is not satisfied with care, he or she could pursue other treatment for a reasonable, but not cost-prohibitive price.

Today, the fastest growing health insurance product is a managed care plan with the availability of out-of-network coverage. Patients have been demanding this freedom to choose, and the marketplace has responded. Requiring this type of plan for any senior is not intrusive, but rather advances a developing trend.

Building a point-of-service feature into all health plans under Medicare will not affect any health plan's ability to be aggressive in their cost-containment activities, nor will it limit their efforts to encourage providers and patients to use health care resources wisely. It will simply put pressure on health plans to keep the patient's welfare uppermost on their agenda, ahead of dividends and the bottom line.

The managed care industry has consistently claimed that a point-of-service feature in all health plans would greatly increase the cost of doing business. This assertion is simply not true. The point-of-service feature is not costly. According to a cost-impact study released this year by the actuarial firm of Milliman and Robertson, Inc., at the request of the Patient Access to Specialty Care Coalition, a point-of-service feature built into all managed care plans would place no financial burden on these plans.

Moreover, in testimony before the Congress this year, the Congressional Budget Office stated that requiring a point-of-service feature would not add to the Federal Government's cost of the Medicare Program. Instead, the cost is covered by patients, who expect to bear some additional expense for this point-of-service feature. This cost, however, is not great, and it is a simple actuarial calculation to determine a reasonable copayment. My legislation calls for the managed care plan to share with its potential enrollees the cost schedule for going out of network.

My legislation contains additional provisions to ensure that patients receive the full range of health care services to which they are entitled. It assures access to specialty care, and provides Medicare patients with an enrollee information checklist so they can have adequate and important information to compare the quality of all health care plans offered to seniors. Also, it includes several Medicare patient rights provisions, and a streamlined rapid appeals process within a health care plan, when there has been a denial of care. Finally, my bill places a ban on provider financial incentive schemes which result in the withholding of care or a denial of a referral.

My legislation does not include any provider protection and is not an any-willing-provider bill. Any-willing-provider provisions deal with the contractual relationships between health plans and providers of medical services. The focus of my bill is on patient choice and the health care rights of Medicare enrollees.

Mr. Speaker, H.R. 2350, the Patient Choice and Access Act of 1995, offers Medicare enrollees real choice and real patient protection. It will give the Medicare patient effective protection against the potential for restricting access to medically necessary health care services. Finally, it will provide a quality assurance check on all health care plans to make sure that they are providing the full range of health care services to their enrollees.

I urge my colleagues in the Congress to cosponsor this bill, and to join with me in my efforts to include these provisions in a Medicare reform proposal. Only if this patient component is included in Medicare reform legislation can we be able to say that we have worked to achieve quality health care and Medicare enrollees protection, and preserved patient freedom of choice in selecting health care providers.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. HOEKSTRA] is recognized for 5 minutes.

[Mr. HOEKSTRA 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 Georgia [Ms. MCKINNEY] is recognized for 5 minutes.

[Ms. MCKINNEY addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. GIBBONS] is recognized for 5 minutes.

[Mr. GIBBONS addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

SUPPORT REPEAL OF THE DAVIS-BACON ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from North Carolina [Mr. BALLENGER] is recognized for 5 minutes.

Mr. BALLENGER. Mr. Speaker, Congress is under increasing pressure to balance the budget. The taxpayers are demanding that Government be more efficient and held accountable for the expenditure of their hard-earned tax dollars. The Davis-Bacon Act is the perfect example of a law that is expensive, unnecessary, and difficult to administer. The act must be considered in light of its economic effects as well as its objectives.

The Davis-Bacon Act has long since outlived any usefulness it may have had. The rationale for special wage protection was never very persuasive but the act remains law, adding millions and millions of dollars to Federal construction costs.

Davis-Bacon was enacted to discourage non-local contractors from securing Federal construction jobs by hiring cheap labor from outside of the project area. Proponents of the legislation complained that this practice was disruptive to the local wage structure. When the act was passed 64 years ago, there was no Federal minimum wage or other labor laws with protections for workers. Since that time, Congress has enacted numerous laws to protect the wages and working conditions of all workers, including construction workers.

The taxpayers are the real losers under the Davis-Bacon Act. Some $48 billion of construction spending annually falls under the Act's coverage. In effect, Davis-Bacon is a tax on construction. For example in Baltimore, the Davis-Bacon requirements add between 5 and 10 percent to the costs of inner city housing. Davis-Bacon effectively wipes out much of the good that banks do when they provide lower interest rate loans to such projects.

Clearly, Davis-Bacon drives up construction costs. Electricians in Philadelphia who are working on a Davis-Bacon project are paid about $37 an hour compared with electricians on a private contract who are paid an average of $15.76 an hour. Companies can not stay in business paying $15 to an employee who is worth $6. If companies have to pay $15 per hour, they are going to hire skilled workers, thus effectively shutting out those who need the opportunity to acquire job skills and work experience.

The total cost of Davis-Bacon extends to State and local government construction programs, this having the same practical implications as an unfunded mandate. Davis-Bacon is particularly burdensome in the area of school construction, by restricting the ability of school districts to reduce construction costs. For example, the cost to build two schools and an academic center in Preston County, WV, could have been reduced by one-third or $1.9 million dollars, had the projects been exempt from Davis-Bacon. The savings could have been realized for the taxpayers or used in other ways through the educational system.

There are additional costs to Federal agencies, which must collect, process, and disseminate thousands of wage rates. Likewise, there are direct costs to contractors who must comply with the recordkeeping and paperwork requirements under the Copeland Act. Compliance costs to the industry total nearly $100 million per year, money which could be better spent creating additional jobs.

Recently, an investigative report was released which detailed fraud in the survey process used by the Department of Labor to determine prevailing wages in certain areas in Oklahoma. The report uncovered numerous instances of interested parties claiming phantom projects and ghost employees, all with the intent of inflating the official wage rates issued by the Department of Labor. In some cases, employees were allegedly paid $5 to $10 an hour more than actual market wages in the area. After repeated demands by local authorities and the involvement of members of the Economic and Educational Opportunities Committee, the Department of Labor revoked the wage determinations in Oklahoma City and Tulsa because of the allegations of fraudulent data. Scandals of this nature erode public confidence in the Government procurement process.

Repeal of the Davis-Bacon Act would have the taxpayers $2.7 billion over 5 years. It would allow the Federal Government to get more construction for the money, or to get the planned construction done for less money. Over 4,000 petitions were sent to Congress from taxpayers across the country supporting repeal of the Davis-Bacon Act. Last November, the voters sent a message to Washington. They want to end Government that is too big, costly, and intrusive. I urge my colleagues to support repeal of the Davis-Bacon Act.

□ 1730

REMOVAL OF NAME OF MEMBER AS A COSPONSOR OF H.R. 2072

Mr. FOX of Pennsylvania. Mr. Speaker, I ask unanimous consent to remove my name as cosponsor of H.R. 2072.