

Compliance, but it has now had to be filed in Federal Court against our own Architect of the Capitol. Now they are about to embark on costly interrogatories, which of course comes out of our budget, or the funds that we allocate to the Architect of the Capitol.

This body needs greater oversight of the Architect of the Capitol and of the new Office of Compliance when a suit can get this far. Apparently these people were willing to settle. And when a party is willing to settle, it is usually on the basis that they may not get everything that they want, but what they certainly are entitled to is to have their work reclassified so that they are paid for doing the work they are performing. And, of course, in any such case there would be back pay.

What we are talking about here, to make myself clear, is that laborers who are men make more money for doing the same work as custodians, formerly called charwomen, who are women in the House.

When the President of the United States in his State of the Union message for the last several years has gotten to the part where he talked about equal pay for equal work, all Members rise as if to salute in majesty the women of America. And yet right here, in the House where we work, the first class action certified has been a simple equal-pay case of the kind rarely found in civilian society today. If this case goes much further, it will become an open embarrassment to this body.

As my colleagues are aware, there is no disagreement among us when it comes to the Equal Pay Act, passed in 1963. We all agree that if women are doing the same work as men, they should not be paid less, and in this case perhaps as much as a dollar or more less, by classifying them by some other name. Whether we call her a laborer or a custodian, we must pay her under the act for the work she is doing.

I regret that the case has gone this far. I feel it is my obligation, as a former chair of the EEOC, to bring this matter to the attention of Members. Because I am certain that Members on neither side of the aisle understand or know or have reason to know this case has gone this far, and that when we go home into our districts women are likely to ask us how in the world have we allowed ourselves to be sued by our own employees for not paying them the same wage as men for doing the same work.

It is time that we rectified this situation. If not, I can assure my colleagues, I have spoken with the plaintiffs, I have spoken with their lawyers. There is no turning back now. They are not afraid that it is the Congress of the United States that is involved. After all, we said in passing the Congressional Accountability Act that we wanted to be treated the way civilian employers are treated. Please treat the

women who clean our offices the way we would want always to have people treated under our jurisdiction.

#### TRIBUTE TO THOSE WHO SERVED IN THE KOREAN WAR

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

Mr. SHIMKUS. Mr. Speaker, at 22 years old, a young man, a loving husband, with yet an unborn child, was called to serve the United States Government in the Army. He served 21 months active duty, 11 months in Korea. During that time in Korea, his first son was born.

□ 1645

He served and returned home. Upon his return, he continued being a model citizen, raising seven children. The young man in this story is my father. He is emblematic of all our Nation's heroes who served and then went home.

I voted "yes" commemorating the 50th anniversary of the Korean War to thank my dad and all those dads and granddads in our country who laid down their lives for the cause of freedom.

Well done. We will not forget you, and we will not forget your sacrifice.

#### HMO REFORM

The SPEAKER pro tempore (Mr. TANCREDO). Under the Speaker's announced policy of January 6, 1999, the gentleman from Texas (Mr. GREEN) is recognized for 60 minutes as the designee of the minority leader.

Mr. GREEN of Texas. Mr. Speaker, I thank our Democratic leader for allowing us to take the first hour tonight to talk about the Patients' Bill of Rights.

I know that we have been talking about this for many years now it seems like, not only the last Congress but also last year and this year. We actually have a conference committee that is meeting now and had their first meeting. The concern has been expressed. It took that conference committee a good while to meet since it was appointed last year, and the concern was that the conference committee was not reflective of the final vote on the House floor.

But be that as it may, that is the way life is. And so now a number of us are trying to make sure that we continue the effort to have real managed care reform in this Congress, not next year, because the issues are so important.

American people support the need for real HMO reform. In fact, last year, with the bipartisan support of the Norwood-Dingell Patients' Bill of Rights bill, I think most Americans felt like we were going to see some Federal consumer protections. And yet, what we

have seen is a bill passed in the Senate that was much weaker even than current law but that the American people supported.

The Kaiser Family Foundation shows that 58 percent of Americans are very worried and somewhat worried that if they become sick their health care plan will be more concerned about saving money than providing the best treatment.

According to the Kaiser Family Foundation, a full 80 percent of Americans support comprehensive consumer protections. That is up from 71 percent last year. So the support is building; it is not decreasing.

The Dingell-Norwood bill is so strongly supported by Americans, by moderates in both political parties, because it holds five principles that are so important. A person that buys insurance should get what they pay for, no excuses, no bureaucratic hassles. A lot of people think bureaucracy is just a function of the Federal Government. That is not the case. We can have insurance company bureaucracy that just cause hassles for people.

What we need is an appeals process, independent external appeals, that if an insurance company or HMO company decides that you should not have a certain procedure, then you should be able to go to someone, an outside appeals process, that will work and be swift. Because if it is not swift, then they will just delay the coverage; and health care delayed is health care denied, Mr. Speaker.

In an experience in Texas, and we have had an outside appeals process since 1997, so we have had over 2 years of experience in Texas with an independent appeals process, and frankly a little over half the appeals are being found for the patient.

My constituents in Texas say, well, we would rather have better than a chance of a flip of a coin when somebody is making a decision on our health care. So we need to have an independent external reviews process that is timely.

And again, the Texas experience shows that it is not that costly. In fact, it has actually cut down on lawsuits; and I will talk about that later. But it is being found in favor of the patient over half the time. And that is what is important, the people are getting their health care that they deserve quickly.

The second issue is that we need to eliminate gag clauses from insurance policies, that physicians can communicate openly and freely with their patients. A lot of companies are already doing that. And that is great. I want to congratulate them. But we also know that that standard does not only need to go from A-B-C company to X-Y-Z company, it needs to be a standard that everybody ought to feel comfortable with no matter who their insurance carrier is. They ought to be

able to go to their physician and be able to have that physician tell them the best possible treatment.

Now, whether their company covers it or not, that is not the case. It is the physician that ought to be able to talk to their patient.

Third, a person who buys insurance ought to be able to have access to specialists. Women and children who are chronically ill should not need to get a referral every time they go see a physician. If you are a cancer patient or if you are a heart patient, or whatever, you should be able to go to your cardiologist or your oncologist without having to go back to your gatekeeper every time. Because, again, that is bureaucracy thrown up by the private sector, not the public sector, to ultimately limit people's ability to go to the doctor.

The access to specialists is so important. I have a situation in my own district. I have a young lady who is in Humble, Texas, the northeast part of my district, and she was getting treatment at a local hospital complex that was close to her; and, all of a sudden, that doctor in that complex lost their contract; and so she was sent across town to Pasadena, Texas, which is also in our district. And that is great; I like them to go in our district. But, Mr. Speaker, for a person to go from one community to the other community because the HMO provider changed the contract is just wrong. Because, again, they were making her travel a great distance to get that specialist care that she needed.

The fourth issue that needs to be included is that, when someone buys insurance, they need to know that they can get emergency treatment, they can go straight to the hospital.

We all know the reason HMOs are successful. They go to providers and say, we guarantee you a thousand or 5,000 or 10,000 patients; and so they will go to the doctors, the hospitals, and emergency rooms and say, we will put you on our preferred list and that way you will get patients.

The problem is that when someone has an emergency, they need to be able to go to the closest emergency room possible. And again, I use the example and have used on the floor here of the House many times that, if I am having chest pains in the evening, how do I know that it is not a heart attack and it may just be the pizza I had. I need to go to the closest hospital or the closest health care provider. And then once the decision is made, then you can go on to your hospital that has a contract with your HMO provider. But you need to be able not to have to pass by emergency rooms to go to an emergency room that may have a contract. So that is important.

Also, oftentimes you cannot always get preauthorization for emergency room treatment. The last thing people

need is to have the toll-free number and to be put on hold while they are having their chest pains or whatever illness or emergency they may be having.

Fifth, a person who buys insurance should be assured that an insurance company is accountable if that insurance company is making decisions in the place of a health care provider or doctor. And we need to make sure that the decision maker is the one responsible and that the decision maker be held accountable if that patient is harmed by that decision.

I would like to tell a story. I spoke a couple of years ago to the Harris County Medical Society, Mr. Speaker; and after it was over, during the speech, I talked about my daughter who had just started medical school. She had been in medical school for 2 weeks. And I laughed and I said, my daughter is in medical school. She has been there for 2 weeks, but she is not ready to be in competition to do brain surgery.

After I finished talking about Social Security and the budget and everything else, the first question was a doctor said, you know, your daughter, after 2 weeks in medical school has more training than the people who are telling me how to treat my patients.

That is wrong, and that is what we need to change. And that is why real HMO reform is important. If doctors are being second guessed by a decision-maker who may not have the training that they need, that decision-maker needs to be accountable.

Hopefully, they do have some training and they are. I know the ideal for HMOs and managed care is it can work. But what we have seen in our country is that the managed care issue and the companies have gone from providing whole-person coverage to actually denying coverage in a lot of cases.

That is why one of the most important parts of the bill that passed this House with an overwhelmingly bipartisan vote was the decision-makers need to be accountable. If doctors are accountable, then decision-makers need to be if they are telling those doctors how to practice medicine.

Now, what we will hear from the insurance company, and we have heard it when this passed that bill last year, is that we are going to have the cost increases, that we will see the cost of insurance going up. Well, Mr. Speaker, we had increases in HMO costs this last year and that bill had not even become law yet. So I think we are seeing increases where that happens.

Again, going back to my own experience in the State of Texas. The State of Texas passed what I consider and I think a lot of folks around the country consider the best managed care reform in the country in 1997; and there had been no overwhelming increases other than what happened based on HMOs increasing everywhere.

Dallas, Ft. Worth, Houston, Harris County, there have been no increases based on Texas law as compared to other parts of the country that do not have it. Typically, they have increased the same. So we have not seen a huge number of lawsuits or cost increases.

The other thing they say, well, you are opening up the court system to lawsuit. Again, after 2 years' experience in Texas, we have not seen but four or five lawsuits filed. In fact, three of them are filed by one attorney in Ft. Worth, Texas.

What we have seen, though, is that if you have strong accountability and strong independent reviews, the independent reviews actually will take the place of having to go to the courthouse.

In fact, people do not want to go to the courthouse. They typically want the health care. And if you have an external appeals process that is swift and fast, that will save people from having to go hire an attorney and go to the courthouse.

Again, in the State of Texas, because over half the cases of the appeals are being found for the patient and the insurance companies are saying, okay, we will pay for that, there is no reason to go to the courthouse. Frankly, if the insurance company is found to be okay, their decision had some medical benefit, then that gives that patient a little saying, well, sure you can go hire your attorney, but now we know when everything is on the table. So we have not had that overwhelming cost increase.

One other thing I want to mention is the concern about employers being sued. In fact, in our debate last year and even as recently as last week, I had an employer express concern that, I do not want to be sued. In the Dingell-Norwood bill, or the Norwood-Dingell, depending on which side you are on, I guess, there is specific language in there that prohibits an employer being sued unless this employer is making medical decisions.

Again, I use the example of my own experience of purchasing insurance before I was elected to Congress for a small company. And we contracted with three different insurance companies, or contacted them to get prices, and we were not in the position of making those medical decisions or saying to deny coverage.

Now, we could buy a Chevrolet plan or we could buy a Cadillac plan. But employers should not be held responsible. In the bill that passed this House, employers are not responsible, although we are hearing that thrown up by a lot of these associations here in Washington, and sometimes I think they mostly want to raise funds and get membership instead of actually address the problem of people having real health insurance that their employers buy. And, as an employer, we paid for

that insurance. And I wanted to make sure that my employees received the insurance that we paid for, and oftentimes I felt like I was the arbitrator between the insurance company and my own employees because oftentimes they did not want to pay.

We have some great Texas experience over the last 2 years. I know other States have passed legislation like what Texas has passed that set the groundwork. It is ideal. We have used the States as a laboratory. We see it has worked in Texas in a large, urban State with both rural and urban area, both poor and wealthy population. It is something we can do on a national basis to make sure that every insurance policy, not just those that are licensed by the State Board of Insurance in the State of Texas or the Insurance Commission, but all insurance policies are covered.

The reason we have national legislation is that over two-thirds of the insurance policies in my own district in Houston are not covered by State law. They are covered under ERISA. They are covered under Federal law. And that is why we need to pass Federal law to complement what the States can do.

I see that my colleague, the gentleman from Texas (Mr. RODRIGUEZ), is here and my colleague, the gentleman from Arkansas (Mr. BERRY), is here. It is great to have two Members from our part of the country who do not have accents speaking.

Mr. Speaker, I yield to my colleague, the gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I want to thank my distinguished colleague, the gentleman from Texas (Mr. GREEN), for yielding; and I appreciate his leadership in this matter and also the leadership of the State of Texas. I believe they were the first State to actually deal with this on the State level, and it is a good thing.

□ 1700

It is amazing to me, Mr. Speaker, that here we are, it is 5 o'clock in the afternoon, and we are doing special orders. That is not what the American people sent us here to do. They sent us here to deal with things like the Patients' Bill of Rights, prescription drug coverage for our seniors, many other issues that we need to be taking care of. Yet here we are basically shut down at 5 o'clock in the evening.

Mr. Speaker, 80 percent of the American people have private health insurance plans. They are enrolled in managed care plans. In many cases, they are required to be enrolled in managed care plans because their employers have contracted with these companies to achieve cost savings. We need managed care. We know that we have got to control the cost of health care. But it can be done right. We must leave the

health care decisions to our professionals, the people that know what they are doing when they make a decision. It should not be left to someone with no training and their only objective is to save the insurance company money.

Unfortunately, because we are enrolled in managed care plans, patients are forced to battle with their HMOs when their only concern should be to recover from an illness. There have been many stories from people who have lost loved ones or had loved ones seriously damaged because someone behind a desk, not a doctor, made a bad decision. The Norwood-Dingell bill allows managed care, and it allows it to do what it is set up to do; and at the same time it protects businesses from unnecessary lawsuits and does the job that we are going to have to do to continue to have managed care in this country.

Last October, the House passed a sound Patients' Bill of Rights, the Norwood-Dingell bill that gave the protection and rights to medical patients. While we delay passage of a strong bill, millions of American families needlessly suffer from the consequences of allowing HMO bureaucrats to make medical decisions. The American people deserve a Patients' Bill of Rights.

This is not a Republican or a Democratic issue. When you have a heart attack and you need to go to an emergency room, they do not ask you which party you vote in, which party you support. We need a Patients' Bill of Rights that ensures patients receive the treatment that they have been promised and paid for, that prevents HMOs and the other health plans from interfering with doctors' decisions regarding the treatment of their patients, ensures that patients could go to any emergency room during a medical emergency without calling their health plan for permission first, ensures that health plans provide their customers with access to specialists when needed because the complexity and seriousness of that patient's illness, allows HMOs to be sued or held accountable if a patient is denied care in States that choose to allow such suits.

The American people are asking us to pass this legislation. Both Democrats and Republicans want this legislation to become law. Let us give the American people what they want. Let us do what we were sent here to do. We all need to take a stand for the rights of managed care patients and make sure they receive the high quality of health care they deserve. We need to pass a Patients' Bill of Rights that is meaningful and that provides real patient protections.

I know with Democrats and Republicans working together, we can put together a strong bill in the conference committee that will give us the protections that will protect business, that

will provide for an efficient system to provide health care for our people. It has been 4 months since the House passed this bill. It is time for the House to do something about this. It is time for the Senate to do something about this. The American people should not have to wait any longer. We need to get to work on finishing the job that the American people sent us to do.

Mr. GREEN of Texas. Mr. Speaker, I want to compliment the gentleman from Arkansas (Mr. BERRY) for his leadership on this issue not only here on the House floor tonight but for the last over a year with our moderate-conservative coalition of Democrats, our Blue Dog Coalition. And I will not ask you what a Blue Dog is, but your leadership has helped a great deal.

Mr. Speaker, I yield to my colleague from San Antonio, Texas (Mr. RODRIGUEZ), a former roommate for a year and served with him in the State House when I was in the legislature.

Mr. RODRIGUEZ. I thank the gentleman from Texas (Mr. GREEN) for taking the leadership to talk about the importance of access to health care throughout this country. Managed care reform is needed drastically.

I will just quickly give an example of some of the problems we have encountered in Texas. We have recently had a situation where one of the particular companies decided to cut a lot of the rural counties out from having access to health care. The reason why is the reimbursement on Medicare is lower for rural areas than it is for urban areas, so there is definitely areas that we need to work on to make sure that those people in rural Texas and rural America also get the same type of access to health care that is drastically needed.

In addition to that, one of the things that I know the gentleman from Texas (Mr. GREEN) knows full well is the fact when we talk about the Patients' Bill of Rights, the right for everyone to be able to see the doctor of their choice, especially when they encounter a situation where they need to see a specialist, an accountant, an insurance person should not be the one to dictate whether they should see that doctor or not. It should be that particular doctor, the one to have the say-so.

So the Patients' Bill of Rights that we have been pushing for the last 2 years is critical. I am hoping that the Congress will decide to do the right thing on an election year, and hopefully we will be able to make something happen when it comes to the Patients' Bill of Rights bill. I also wanted to touch base, and I know the gentleman from Texas (Mr. GREEN) knows full well the fact that we have a large number of uninsured in this country. It has gone over 44 million now. Texas is one of the largest of uninsured individuals. We are talking about individuals, working Americans, working Texans.

These are people that are making too much money to qualify for Medicaid, not old enough to qualify for Medicare, yet at the same time are not making a sufficient amount of resources to be able to cover their families and have access to insurance.

I know that the CHIPs program, the children's insurance program, has been a great program that has been in the forefront and thank God for President Clinton's effort and the Democrats in pushing that program forward. But we still have a lot to do. States such as Texas, for example, that was one of the last States who actually moved to approve the CHIPs program, decided to move and only fund 55 to 60 percent, so that means that 10 kids that qualify, we will only be able to service six of those based on the resources that were allocated.

So there is a real need for us to reach out and making sure that those youngsters get access to health care. I know from a Hispanic perspective, and I head the task force for the Hispanic caucus, we want to make sure that the parents of those children also have an opportunity to get insurance. Those individuals, those parents are also parents that are out there working hard and trying to make things happen for their families. We are hoping that we can expand that CHIPs program to the parents of those children to make sure that they get access to health care.

Aside from the fact that things are getting worse in terms of the uninsured and things seem to be getting worse also for managed care systems, we also need to look at Medicare. In the area of Medicare, it is ironic to think that right now if you are on Medicaid for the indigent, you get access to prescription coverage. Yet if you are a senior citizen, you do not have access to prescription coverage.

It does not make any sense. It was started, Medicare, during a time when not too many prescriptions were being utilized in the area of getting people taken care of, and now there is a need for prescription coverage and the cost to those senior citizens as we well know is astronomical. In fact, studies that were done throughout this country and specifically in my district, we did a study and we found that our senior citizens are getting charged more for the same prescription than someone who is on a major insurance company. So that the pharmaceutical companies are basically giving breaks and giving discounts to individuals, but when it comes to our senior citizens that are on Medicare they are not getting those same prescription coverages.

I know that they are spending a lot of money on lobbying; I know that again some of our legislation to allow our senior citizens to have access to Medicare, but it is something that I feel real strongly about, that we need to make sure that our senior citizens

get that access to that prescription coverage and if nothing else for them to get it at the same cost that those other individuals get when they go out there and purchase that prescription.

One of the other things when we look at the issue of health care, and it goes beyond in terms of not only the uninsured, the importance of prescription coverage but also in terms of veterans. Last year we worked real hard to try to get a \$3 billion increase in the veterans for access to health care. I know that in committee, the Republican side fought us extremely hard. They also fought us on the House floor on an amendment to add those \$3 billion. We were able to add \$1.7 billion. This year, I was real pleased to see the administration come up with a \$1.5 billion increase on veterans health care; but in all honesty, that is just to keep up with existing cost.

There is a real need for us to reach out to those veterans. There is a need for us to make sure we fulfill that agreement that we made to all those veterans out there to have access to health care. One of the things that I have seen up here in the last 3½ years is the fact that as Americans and as agencies that are responsive and talking in our behalf, they definitely did tell our veterans that they were going to have access to health care. That is one of the things that we have neglected to do.

One of our obligations is that we have to make sure that those individuals get access to that health care. This year, we are moving forward to try to fulfill some of those needs in the area of veterans needs as well as TRICARE. If I could, I want to just touch base with the gentleman from Texas (Mr. GREEN) on TRICARE. TRICARE is an issue of those retirees that are out there. A lot of them are having a great deal of difficulty, and these are the retirees, military individuals, a little different than the VA, a different source; but it is one of the areas that they are also having a great deal of difficulty. We are hoping to put some additional resources in that area and to make some things happen for our military retirees that are out there. In conjunction with all the other needs that we have on health care, there is a real need for us to move forward in these areas.

I want to thank the gentleman from Texas (Mr. GREEN) for the leadership that he has taken in this area.

Mr. GREEN of Texas. I thank the gentleman from Texas (Mr. RODRIGUEZ) for being here today. In fact you have covered so many issues that are important. TRICARE obviously even in Houston where we do not have an Army medical hospital, a Navy hospital or whatever, we have a VA but we have a lot of veterans. It is an issue there. You were in the state legislature and a State House member in 1995.

Mr. RODRIGUEZ. Yes, I was.

Mr. GREEN of Texas. In 1995, the State of Texas passed the first strong managed care reform bill, HMO reform bill, passed both the House and the Senate and the governor vetoed it in 1995.

Mr. RODRIGUEZ. Exactly.

Mr. GREEN of Texas. In 1997 you were elected to Congress in a special election, I believe.

Mr. RODRIGUEZ. Yes, I was.

Mr. GREEN of Texas. Were you in the legislature in 1997?

Mr. RODRIGUEZ. Yes, I was.

Mr. GREEN of Texas. You remember when the legislature passed the HMO reform bill or managed care reform bill in Texas and it was passed by the legislature and it became law this time, though; but the governor did not veto it, he did not sign it, it became law without his signature.

Mr. RODRIGUEZ. That is right.

Mr. GREEN of Texas. That is the history of managed care reform in Texas. There are things that I am proud to be a Texan always; but obviously we have not done as well as we should on the CHIPs program and those prescriptions that you talk about on Medicaid; I think our seniors in Texas only receive three prescriptions. That is better than none, obviously, if you are poor and on Medicaid.

Mr. RODRIGUEZ. Let me just share in that area, other States actually get more. We as a State have chosen not to participate fully on that. That is why we only get three prescriptions, because the State chooses to put a limit on those prescriptions. In fact, I authored some legislation to force the Texas House to move forward on that, and I was able to get six prescriptions if you are in a nursing home, six prescriptions if you are in a hospital; but if you are at home, you still just get three.

Mr. GREEN of Texas. That is just for people who qualify for Medicaid.

Mr. RODRIGUEZ. That is right. Medicaid, which means indigent. One of our biggest problems as you indicated is those people who make a little bit above the indigent level, which is \$12,700 a year for a family of three, those that make a little bit over that find themselves not being able to qualify for Medicaid but find themselves without any insurance whatsoever and having a job where they cannot afford to have insurance.

The other issue as we well know is the issue of Medicare. That is an issue that also we find ourselves with a lot of senior citizens not being able to have access to prescription coverage.

Mr. GREEN of Texas. Let me get back to our managed care issue. Sometime we can have a discussion on the floor on that. I know I have some other colleagues who are going to be here. Mr. Speaker, let me talk about some of the numbers that we have seen. I

quoted earlier the Kaiser Harvard study of doctors. Almost 90 percent of doctors report denials by managed care plans of services they requested for their patients.

□ 1715

We can see how many, over 80 percent overall portion of doctors saying their request for some type of health, 87 percent; 79 percent portion saying their request for prescription drugs had been denied; 69 percent portion say their requests for diagnostic tests have been denied. Sixty-nine percent of the doctors are saying they have had experience with that.

Again, that is why we need to make sure that doctors can talk to their patients and have the freedom of speech when they talk to their patients.

That is why it is so important that we pass the conference committee work as diligently as we can, but that they make sure they do not send us out a fig leaf, they do not send us out something in an election year that is just saying the House and the Senate passed a managed care reform. We need a real Patients' Bill of Rights, real HMO reform.

This House took the bold step last year and passed, on a bipartisan vote, the Dingell-Norwood bill. That is a strong bill that was patterned after what States have found successful.

I see my colleague from Houston, the gentlewoman from Texas (Ms. JACKSON-LEE). We share Houston, Texas, and I would like to yield time to her.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentleman from Texas (Mr. GREEN) for his leadership. This is a particularly important special order, and it is long overdue for us to find common ground on HMO reform.

It is extremely important because, Mr. Speaker, Americans are asking us in a bipartisan manner to address this issue. I do know that the conferees have been appointed; and I do know, however, that their work is not done and that is really the crux of the issue.

My good friend, the gentleman from Texas (Mr. GREEN), did do very able work, both, I believe, in the House in the State and as well as in the Senate in the State of Texas. I, like him, am proud of the legislators who a long time ago, 1995, and that is a long time ago, 5 years ago, passed a Patients' Bill of Rights. Unfortunately, those bills did not deem to find their way on our governor's desk to be signed, but they were in place.

I think the key that I want to say, besides the fact that it did not get signed by our governor, is that it works; that we have not heard any complaints or any outrageous imbalance that has occurred. It has not gone far enough, of course; but we have not heard any major complaint from constituents or managed care entities or hospitals about how that particular

legislation has worked. I think that is a good point, and the reason why it is a good point because what we have heard in the discussion, even though we managed to get this bill off the floor of the House and passed, is the apprehension and fear of what will happen, what disarray will occur in the insurance industry if we pass a Patients' Bill of Rights.

I just simply want to share these very simple aspects of the Norwood-Dingell bill, bipartisan bill, hard-worked bill, and, Mr. Speaker, I want to know whether or not these are endangering our system as we know it. Direct access to specialty care simply means that if someone is a diabetic or if they have high blood pressure and they need specialists in that area, they can immediately go to their HMO, go to that particular specialist, rather than having the referral.

I have a mother who obviously is a senior citizen, and every time I have to hear her saying I have to get referred to the doctor who deals with diabetes or I have to get referred to the doctor that deals with my heart disease, that kind of almost denial of service to our seniors and others who need this kind of care makes it more difficult for them to access health care. They have to worry about the appointment with the specialty person by way of waiting for the referral to come through, and I think that that makes it very difficult.

Emergency room care is enhanced and improved under the Norwood-Dingell bill. That means that someone is not turned away. We have heard so many tragic stories. One young man, who was an amputee, who was here on the floor of the House, and the reason is because when something happened to him as a little nine year old, I believe was his age, his parents had to travel past a close emergency room because they were not covered or that emergency room said they were not covered.

These are tragedies in America, in a country as wealthy as we are, that should not occur.

The bill also includes an HMO appeals process by a panel of experts and HMO liability for refusal to authorize lifesaving treatments. In essence, it allows one to hold their HMO accountable.

A Kaiser Family Foundation study found that 73 percent of voters believe that patients should be able to hold managed care plans accountable for wrongful delays or denials. The same study also found that 61 percent of patients complained of the decreased amount of time doctors spend with patients; 59 percent complained of the difficulty in seeing medical specialists; and 51 percent complained of the decreased quality of care for the sick. We can address this.

First of all, we can applaud those medical professionals that we do have but we can address this by simply passing the Patients' Bill of Rights.

I would like to share, before I close, a sample of some stories that would argue that we need to hastily run to the conference and get this bill out and to the floor and to the Senate and let it be signed by the President of the United States.

First of all, I think it is important to note that we have a lot more to do other than the Patients' Bill of Rights and that is, of course, we need to deal with the prescription discount for our seniors. I have had a study done in my district. It has shown that one can get drugs cheaper in Mexico and elsewhere other than the City of Houston. It shows that, in particular, my seniors have to take monies that they would use for food and rent to be able to pay for their drugs, a huge cost, \$800 a month or more for some seniors who have lifesaving needs or drugs that provide lifesaving opportunities for them.

Why can we not simply pass a very simple bill that allows for those drugs to be discounted? Why are we not adhering to the heed and the cry of those we pretend to represent and provide seniors with that discount?

As I have said, this Patients' Bill of Rights, a part of HMO reform, really is urgent; and I have examples right out of my community. John McGann found that he had AIDS and thought that he would be covered adequately by his health insurance. When he filed a claim for AIDS-related treatment, he found out that his benefits had been capped retroactively. Since his insurance was through an ERISA group health plan, the State consumer protection plan did not apply. He sued claiming discrimination and lost. Unfortunately, John McGann died, and the ruling on his case was upheld by the Supreme Court.

Therein lies a great need for us to intervene legislatively.

Let me lastly say, Wendy Connelly from Sherwood, Oregon, went to a local hospital with symptoms of what she thought was a heart attack. When she got to the hospital, she found out that she was suffering from a previously undiagnosed thyroid imbalance, not a heart attack, and she might have been at that point a little grateful.

The bill arrived for her treatment and the HMO denied her claim because her treatment was not considered to be emergency care.

The HMO based its decision on her final diagnosis, not on the symptom that caused Wendy to go to the hospital.

Wendy fought the decision by her HMO with the help of her doctors and the hospital. She prevailed on her appeal, but she found out that the denial was a routine practice of insurance companies that emergency room visits had to result in a final diagnosed emergency.

Then what are we saying, Mr. Speaker? That when people feel that they are having a heart attack or some other

dangerous symptom that may result in a loss of life that they should just sit here and say, my God, let me sit down and think is it my thyroid or something else because I will not get the benefit of my HMO that I am paying for because they will deny me the access to emergency room care?

We do want more of our citizens to be preventive or to deal with medicine from a preventive way to take care of themselves, but there are tragedies that are occurring every day. John McGann lost his life. Wendy Connelly was insulted with her HMO denying her a coverage. Joyce Ching had rectal bleeding and wound up dying, who she had in her family, her father died of colon cancer at a young age, and she was referred or denied a specialist, unfortunately, even though she had a history of colon cancer when she had rectal bleeding.

All of those are, I believe, indications, as my colleague has indicated by this special order today, that we are at a crisis in health care. We need to have the Patients' Bill of Rights. We need to have the prescription discount for our seniors; and, frankly, we need to have the Norwood-Dingell bill that will hold HMOs accountable for some of the negative aspects of health care that they generate.

I hope that we can move this legislation along, and I thank the gentleman from Texas (Mr. GREEN) for his leadership on this issue in bringing this particular special order to us. I would frankly say, can 73 percent of the American population be wrong? Can those who believe we can do better be wrong?

I would simply ask that we quickly pass these legislative initiatives so we can bring real health care to the American public.

Mr. Speaker, I rise today to add my voice in support of the Bipartisan Consensus Managed Care Improvement Act, the Norwood-Dingell patient protection legislation. This legislation sets a Federal standard to ensure that Americans will have basic consumer protection in their health care plans.

Americans have waited a long time for us to enact this legislation. This balanced, reasonable legislation represents the best hope for passing meaningful protection from abusive practices for patients.

In the past few years, there has been a dramatic change in the way people receive and pay for health care services. More than three out of four people are enrolled in managed care plans—health maintenance organizations (HMOs), preferred provider organizations, and point of service plans.

Managed care is an attempt to improve access to preventive and primary care, and to respond to high health care costs. Managed care plans were designed to control unnecessary and inappropriate medical care.

However, many Americans believe that instead of improving the health care system, managed care plans have increased the number of problems through bureaucratic redtape and denials of care.

Thus, the reform movement here in Congress sought to give consumers certain protections when receiving health care services. The original Patient's Bill of Rights was one attempt at patient protection legislation. In an effort to propose managed care reform that could be supported by everyone, the Bipartisan Consensus Managed Care Improvement Act was offered by Representatives NORWOOD and DINGELL.

There are four key elements to the Norwood-Dingell managed care reform proposal. These reforms include: (1) direct access to specialty care; (2) emergency room care; (3) an HMO appeals process by a panel of experts; and (4) HMO liability for refusal to authorize life-saving treatments.

These reforms are basic consumer protections that ensure that patients receive the best quality of care needed. In addition, this bill provides for an expanded choice of physicians, access to prescription drugs and continuity of care when a doctor leaves a network.

I support this legislation because I believe Americans deserve quality health care from their managed care plans. I have received many letters from constituents that express their dissatisfaction with the care that they received from HMO's.

A Kaiser Family Foundation study found that 73 percent of voters believe that patients should be able to hold managed care plans accountable for wrongful delays or denials. The same study also found that 61 percent of patients complained of the decreased amount of time doctors spend with patients; 59 percent complained of the difficulty in seeing medical specialists; and 51 percent complained of the decreased quality of care for the sick.

Last spring, many of my constituents used the power of the Internet to add their names to a national online petition in support of the Patient's Bill of Rights. These constituents believed that this legislation was crucial to provide consumers with the basic protections that are necessary to ensure that they receive quality care.

To further illustrate how important this legislation is to the American people, here are some stories of people who have true HMO horror stories:

In Houston, TX, John McGann found out that he had AIDS and thought that he would be covered adequately by his health insurance. When he filed a claim for AIDS related treatment, he found out that his benefits had been capped retroactively. Since his insurance was through an ERISA group health plan, the state consumer protection plan did not apply. He sued claiming discrimination and lost. Unfortunately John McGann died, and the ruling on his case was upheld by the Supreme Court.

Wendy Connelly from Sherwood, OR, went to a local hospital with symptoms of what she thought was a heart attack. When she got to the hospital, she found out that she was suffering from a previously undiagnosed thyroid imbalance, not a heart attack. The bill arrived for her treatment and the HMO denied her claim because her treatment was not considered to be "emergent care." The HMO based its decision on her final diagnosis, not on the symptoms that caused Wendy to go to the

hospital. Wendy fought the decision by her HMO with the help of her doctors and the hospital. She prevailed in her appeal, but she found out that the denial was a routine practice of insurance companies—that emergency room visits had to result in a final diagnosed emergency.

Glenn Nealy suffered from unstable angina and was treated with a strict regimen by his cardiologist. His employer changed health plans, but Glenn was assured that he would continue to be treated. Glenn attempted to go to a doctor that participated in the plan, but after several administrative delays he suffered a heart attack and died. Before his death, he had also requested several times to see his original cardiologist, but was denied.

Joyce Ching from Agoura, CA, died from misdiagnosed colon cancer in 1994. When she complained of severe abdominal pain and rectal bleeding, an HMO doctor told her that her symptoms could be treated with a change in diet. She was refused a referral to a specialist until it was too late. In the early diagnosis stage, the doctor failed to ask Joyce for a family history, which would have revealed that her father also died of colon cancer at a young age.

Buddy Kuhl, from Kansas City, MO, required special heart surgery after a major heart attack. He could not get the surgery in his hometown, so he was referred to a hospital outside of the HMO service area. Initially, the HMO refused to certify the surgery, but later agreed after a second doctor confirmed the recommendation of the first doctor. A few months later, Buddy found that he needed a heart transplant. The HMO refused to pay for a transplant, but Buddy got on a transplant list anyway. However, he died while waiting for a transplant.

In each of these cases, an HMO bureaucrat made a decision that caused the death, or delayed care for a patient in need. Although Wendy Connelly survived her illness, she had to fight for her benefits. The other patients were not so lucky.

I once heard someone say, "As long as you are healthy, HMO's are fine, but the trouble starts when you get really sick." This statement is a sad commentary on the state of health care service in this country. That is why the Norwood-Dingell bill is so important. People need quality health care whether or not they are sick.

The Norwood-Dingell proposal includes access to specialty care. In the cases I cited several of the patients were denied access to specialists. Joyce Ching was refused an initial referral to a gastroenterologist and Glenn Nealy was refused an initial referral to a cardiologist. In these cases, the delay was fatal. If a specialist is needed, patients should be able to receive those services.

The Norwood-Dingell bill also includes access to emergency room care. Wendy Connelly received emergency room care, but her claim was denied because her final diagnosis differed from the heart attack symptoms she first experienced.

Under this proposal, no patient would be denied a claim for non-emergent care if the symptoms seemed more serious. Emergency care should be available at any time without prior authorization for treatment.

The third major reform is an HMO appeals process by a panel of experts. In each of these cases, an independent review panel probably would have overturned each of the decisions made by the HMO.

The expert panel would consist of an independent group of professionals, not a panel of insurance agents. Particularly in the case of Buddy Kuhl, a review panel would have determined that his condition was too serious to wait as long as it took for a confirmation of the original diagnosis.

Finally, the Norwood-Dingell proposal would impose liability on an HMO for refusal to authorize life-saving treatment. Although this is one of the most controversial aspects of this legislation, the ability to hold an HMO liable for certain decisions is an important reform for patients.

In some of the cases I cited earlier, the victims' families could not recover damages from the HMO because it was governed by ERISA (the Employee Retirement Income Security Act regulations), which only allows a patient to recoup losses caused by the delay or denial of care.

The Norwood-Dingell measure expands health plan tort liability by permitting state causes of action under the ERISA to recover damages resulting from personal injury or for wrongful death for any action "in connection with the provision of insurance, administrative services, or medical services" by a group health plan.

In my home State of Texas, we have The Health Care Liability Act that allows an individual to sue a health insurance maintenance organization, or other managed care entity for damages for failure to exercise ordinary care when making a health care treatment decision.

The first lawsuit to cite Texas' pioneering HMO liability law, filed against NYLCare of Texas, demonstrates why this measure is important. NYLCare's reviewers made the decision to end hospital coverage for a suicidal patient. Despite his psychiatrist's objections, the patient did not protest the HMO's decision to release him from the hospital, and, shortly after discharge, he killed himself.

In her decision in this case, 5th Circuit Judge Vanessa Gilmore wrote:

[I]n light of the fundamental changes that have taken place in the health delivery system, it may be that the Supreme Court has gone as far as it can go in addressing this area and it should be for Congress to further define what rights a patient has when he or she has been negatively affected by an HMO's decision to deny medical care. . . . If Congress wants the American citizens to have access to adequate health care, then Congress must accept its responsibility to define the scope of ERISA preemption and to enact legislation that ensures every patient has access to that care. *Corporate Health Insurance v. The Texas Dept. of Insurance*, 12 F. Supp. 2d, 597 (S.Tx. 1998).

This case will set a standard for patients who have been denied care or refused treatment. Critics claim that this provision will expand employer liability, but this is not true. Detrimental HMO decisions will effect the HMO, not the employer. As in any case of liability, the decision-maker must accept the consequences of an unwise decision.

The Norwood-Dingell proposal should not be controversial for any Member of Congress who is serious about protecting patients from insurance company abuses. The patients, families, and doctors deserve to make decisions about health care services.

If the health care industry continues to act as a well-heeled special interest group that puts profits ahead of patients, then these reforms deserve our unequivocal support. I urge my colleagues to support this bill.

Mr. GREEN of Texas. Mr. Speaker, I am so glad the gentlewoman from Texas (Ms. JACKSON-LEE) brought up those because oftentimes to pass legislation we have to show the public support and, like the gentlewoman said, over 80 percent support now for a real Patients' Bill of Rights and managed care reform.

We have to show the need for it, not just the public support. The gentlewoman's example of the three people she gave, particularly the last one, and March being colorectal cancer month it is so important that we look at our family history and that HMO and the physicians need to look at that so someone can go and be screened to make sure, because colorectal cancer like anything else, the earlier the detection the more chance there is of survival, and the less money it will cost for treatment.

All of us do lots of newsletters, Mr. Speaker, and I know I read all of mine, particularly the ones that people write in and give particular opinions. So we sent one out and had town hall meetings in January and February of this year and so some interesting ones came back, particularly on HMO reform, and to point out the need for it. This person from Humble, Texas, part of the district I represent, every time I get my referral, my 6-month referral for my cancer, I get a 9-month checkup not 6 months as I should get, and a lot of things they should pay for they will not.

Instead of a person obviously who has had a history of cancer and has to go back, should be going back for every 6 months, her HMO says, no, she has to go back every 9 months and she has to get permission even to go back for that 9 months.

That is what the Dingell-Norwood bill would change, that that person should go back and get that checkup and they should not have to go back to their gatekeeper before they can go to their oncologist or their specialist, hopefully for a 6-month checkup instead of waiting another 3 months for it.

Another from north side Houston, in fact an area where I grew up, why cannot our family doctor have more control over us in the hospital? Please answer why that is the case.

Well, what happens with HMOs is that they will assign a physician to

someone and their family doctor or their gatekeeper that they have selected oftentimes loses that control. Let me give an example of what happened in my own district. We had an individual in Pasadena that the HMO doctor came in, the family doctor or their gatekeeper said this person actually was terminal, with cancer, and the HMO doctor came in and said, you need to be released, you cannot go here and if you come back to the hospital you have to go across town.

So those constituents contacted our office and they expressed, our father is terminal and even our family doctor said he should stay in. After talking to that insurance company, they understood the error of their ways and they agreed to let that patient stay in there.

A person should not have to call their Member of Congress to get adequate health care. We should be able to pass the legislation, have the President sign it and they should not have to do that so that HMO doctor, who was assigned, cannot go in and say you need to be released, not consulting with the family doctor. That came again from North Side Houston.

I had another case in Pasadena. East End, in fact we share near East End where our new ball park is going to go up and the Astros are going to have their opening game, make HMOs accountable for better care. They have had horrible experiences. This is from Hagerman, near East End, almost in the district of the gentlewoman, but part of my district in East End Houston.

Again, these are newsletter responses that come back and say how they need. Remove restrictions that HMOs and PPOs place on doctors. Again, the gag rules that are placed on them and also the restrictions that a doctor cannot say what to do.

That is why this House last year passed a strong Patients' Bill of Rights bipartisanly and that is why the conference committee hopefully will, as we say in Texas, get up and do what is right. We need to do what is right and pass something for the whole country, not just say in Texas. I imagine the percentages in the district of the gentlewoman are the same. Two-thirds of the insurance policies in my district come under Federal law and not State law. So only a third of the people have the protections they have.

Two-thirds of the people need us to pass a bill that is as strong as the bill for Texas, that they did in Texas, and that is why it is so important.

Ms. JACKSON-LEE of Texas. Mr. Speaker, will the gentleman yield?

Mr. GREEN of Texas. I yield to the gentlewoman from Texas.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I appreciate the gentleman sharing with us real-life stories because every time we do have our town hall meetings or we interact with constituents, there are a number of tragic

stories. As I indicated, Mr. McGann passed away. He was suffering from HIV and was distraught to find out that his illness, which we all know now is an illness that can attack almost anyone, was not covered. It did not provide him the care that he needed.

□ 1730

What we need to do is to break the shackles or the intimidation process, so that, as the gentleman has so aptly said, access to health care does not have to be on the order of getting permission from the United States Congress, meaning that Congresspersons have to then intervene on behalf of their constituents to get simple health care.

Mr. Speaker, I want to bring up the point of the specialty care and the block that most individuals get. It may be that they are suffering from sickle-cell; it may be that they are senior citizens with a number of ailments. People do not realize how difficult it is to get around as a senior citizen and to go to one primary care physician just to get, it is almost a ticket, just to get a slip of paper to say that you are referred to a specialist.

Then one has to wait for a long period of time for that specialist to have time on his calendar, if you will, a physician's calendar. That is not necessarily an attack on the physician who is overwhelmed and overworked possibly, but then one has to wait to be seen by that particular specialist which delays one's diagnosis, and it also speaks to what the gentleman has just noted. The person who needed a 6-month checkup is given a 9-month. Why? Not for any other reason but to save money. But it is well known that the illness that they have needs a 6-month detection.

So what we are asking for is that there should not be a bar or a closed door to the need of our citizens to get health care in this great country where they are saying in one voice, whether it is the east end or the fifth ward, or whether it is the Heights, whether it is downtown Houston since that population is growing. I have heard that the stories do not respect whether or not one is a working person with an income of \$25,000, someone who does not have health insurance, or someone who happens to be well-to-do. The problem is that the HMO, if you will, ties the hands of those who need health care; and we need to have those hands untied.

Mr. GREEN of Texas. Mr. Speaker, I thank my colleague from Houston. That is so true. That is why this is not an issue of economics or demographics or anything else, whether one makes \$100,000 a year, \$25,000 a year. If one is in an HMO, one's health care can be delayed, it can be denied, unless we pass a strong managed care HMO reform bill.

One of the issues I talked about a little bit earlier, and I want to address particularly, because I do not know if my colleague has heard about it, but I have, and particularly in meeting with some of my employers in the district, and that is again, their fears that they will be sued. I want to quote from the bill, section 302 of the bill that passed this House that says: nothing in this subsection should be construed as a cause of action under State law for the failure to provide an item or service which is specifically excluded under the group health plan for the employer. It does not authorize any cause of action against the employer or other plan sponsor maintaining a group health plan or against the employee of such person.

The intent of this legislation is not to sue the employer or sue the employee of that employer unless they are making those medical decisions, unless they are involved in it. Again, my real-life experience before getting elected to Congress is that employers do not make that kind of decision. Employers go out and buy an insurance plan, what they can afford; and they do not decide whether someone should go to this doctor or that doctor or this hospital or that hospital. That is up to the plan to make that decision, with the premiums that they charge.

So this bill actually prohibits lawsuits against the employer or the employee of that employer, based on health care, unless that employer is making that decision. Again, that is not the case. I do not know how we can make it any stronger. Frankly, during the debate last year on this legislation, I asked some employers, I said, if you can make it any stronger, please give me the language and we will make every effort to put it in. I never received any language.

So this bill, the Dingell-Norwood bill, does not allow for employer lawsuits. So that is one of those straw men that get thrown up oftentimes during legislative debate. But managed care reform, real managed care reform, over 80 percent of the people support: Democrats, Republicans, Easterners, Westerners, Midwesterners. And that is why this Congress needs to pass it. If it is not in the year 2000, then hopefully the voters and the folks will remember this November that this Congress needs to be responsive to their requirements, particularly when we see 80 percent, and we hear the examples that we have given today and heard about.

That is why it is so important that this Congress address a real Patients' Bill of Rights and include the 5 issues that we want to make sure they have: independent appeals, so they can get a timely medical decision; that we can eliminate those gag clauses; that we can have access to specialists; like my colleague said, women can go to their OB-GYN, not only for a specialist, but

for their primary care; adequate emergency room service, and again, the example of not having to pass by an emergency room, or going to an emergency room with pain and then the doctors find out that you have some other illness and say no, you should have gone to your regular doctor. That is not the case. The issue is that they were experiencing pain originally, and whether it was the thyroid or heart or whatever should not matter.

The last point, the best one, we can pass all of the legislation that we want in this bill, but if it does not hold the medical decision-maker accountable, if the person is telling that person no, you should not get that test, if that person is not accountable, and again, they have been accountable under Texas law now for 2½ years and we have not seen a huge number of lawsuits. Again, Texans are not normally shy about going to court if they feel that they are aggrieved.

Mr. Speaker, I yield to my colleague.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentleman for that very excellent summary. I just wanted to go back to the point about pain, because the new science from medical professionals is that we should listen to the signals of pain. Just as the gentleman has indicated, here we have HMOs who tell us to go back home because in the example that I gave, she thought she was having a heart attack, but it happened to be thyroid, so that is contradictory to what the medical professionals are telling us, which is to listen to pain symptoms and act on them and not to ignore them.

Let me just add that we holistically need to look over all at health care, and I hope at some time we will be able to pass the mental health parity bill. I think all of us have been supportive of that. That has not come to the floor. It has been filed every year, but we have not done that.

Then, one of the issues that we need to continue to address, and that is why we should know that we are not solving everything with the Patients' Bill of Rights, so people who are fearful of it should realize that there are still issues to deal with.

I have an omnibus mental health bill for children called Give a Kid a Chance, which is to give greater access to mental health care to our children and our families. There is certainly evidence through what we have seen in gun violence and children using guns that families are in great need of support systems. Mental health is a health issue, but we have not yet been able to address the question of mental health the way we should in this Congress.

So I hope that this Special Order today emphasizes not only the HMO reform, but the overall need of addressing health care issues. I am looking forward to bringing my mental health

bill both to committee and then to the floor of the House. But I want to do that as we move the Patients' Bill of Rights along, as well as the prescription drug discount, and finally address the questions that Americans have asked us to address.

I thank the gentleman for yielding this time to me and for bringing to the attention of this Congress the need for HMO reform. I am happy to yield back to the gentleman.

Mr. GREEN of Texas. Mr. Speaker, I thank my colleague again, because there is no doubt that this Congress needs to address a broad range of health care. We have a bill that passed the House, that is a strong Patients' Bill of Rights; and we need to take one step at a time, Mr. Speaker. If the conference committee will come out with a strong Dingell-Norwood bill just like passed this House, then we can put this issue behind us and we can address health care for veterans; we can address mental health and get on to other issues that are important.

But, first of all, when people pay a premium, they have to make sure that they receive the health care that they are paying for; and that is what is so important about this Patients' Bill of Rights. They have to know that when they pay the money for their premium, that they are getting health care and not just getting a denial slip or delayed health care, because someone is making a decision that they are looking at the bottom line instead of the health care of that person.

Mr. Speaker, again, I thank not only our Democratic leader, but also the colleagues of mine who have been here tonight.

Mrs. MALONEY of New York. Mr. Speaker, last session, this House passed a sound and responsible managed care reform bill with solid support from both sides of the aisle.

The conference committee has finally met and the appointees are now negotiating critical provisions such as direct access to OB/GYNs for women and direct access to pediatricians for children.

Faced with a daunting number of managed care reform bills, our fellow lawmakers in all 50 state legislatures are urging us to take action soon.

Their pleas echo those of millions of patients, family members, and providers who feel disenfranchised and exploited by the Big Business of Big Medicine.

These are real patients with real diseases, real pain, and real fear.

We have heard for so long about the onerous obstacles that patients face in getting the care they need.

We have come together as a House to pass sound legislative remedies.

Now let us finish the job we began last session without further delay.

Mr. Speaker, these patients don't have any more time to wait, nor should they have to wait . . . We owe it to them to finally deliver the relief that is promised in the Norwood-Dingell bill.

And the Patient's Bill of Rights isn't just about patients—it's about beleaguered health care providers gagged from speaking their expert opinion and prohibited from practicing to give the best medicine they know.

No single piece of legislation passed during this Congress has more support and more urgency than the Patients' bill of rights.

I call on my colleagues assigned to the conference committee to waste not one more minute in bringing this legislation to the desk of the President, so that the Patients' Bill of Rights can become law.

#### DEPARTMENT OF EDUCATION UNAUDITABLE DUE TO SLOPPY RECORDKEEPING

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

Mr. HOEKSTRA. Mr. Speaker, I want to talk tonight about some of the work that we have done in our committee over the last few months, and I chair a subcommittee that has oversight responsibility for the Education Department.

It was back in October, October 29, that me and some of my colleagues from the committee, the gentleman from Colorado (Mr. SCHAFFER) and the gentleman from Arizona (Mr. SALMON), walked down Capitol Hill. We walked to the Department of Education. We wanted to meet with some of the people at the Department of Education, and we wanted to meet with Secretary Riley to find out if we could help the Secretary find a penny on the dollar of savings. It was when we were going through the budget negotiations and a various range of activities. One of the things that we were saying is, can we find some savings in our various departments so that we can stay within the budget caps, make sure that we do not raid Social Security and actually develop a surplus in the general fund, as well as in the Social Security fund.

Well, when we went there that day, we found out some interesting things. For 1998, the fiscal year of 1998, the Education Department had just received their audit, the financial audit completed by Ernst & Young, which is a report that Congress mandated that every agency go through, that they bring in independent outside auditors to review the books. What did we find out? We found out that for 1998, the Education Department was 7 months late in meeting their statutory deadline. That is the good news. The bad news that we found was that Ernst & Young was not going to give them a clean audit. Actually, they did not render an opinion on any of the 5 financial statements that the Education Department was required to complete. So basically, their books could not be audited.

What we also found out is we went and dug through this, and we found that there was an account called the "grant-back account." It had \$594 million. This is money that is recovered or supposed to be recovered from schools and universities who have had some problems with the grants that they are receiving. They returned this money back to Washington; that is why it is called the grant-back account. It had \$594 million in it. The auditor stated that of this, only \$13 million could actually be attributed to grant-back activities, meaning that over \$580 million of that account could not be reconciled, that the Education Department could not tell us how the money got there, what accounts that this money had come from, or where this money was going to be used. As a matter of fact, under law, most of this money should have gone back to the Treasury, but it was still sitting at the Department of Education.

Mr. Speaker, they receive \$35 billion a year. As they were going through the process, the auditors had found an instance where, in 1998, as they were adjusting their books, they had made a \$6 billion, that is with a B, a \$6 billion adjustment in their books. Now, this did catch the attention of the auditors, and they went back to the Education Department and said, could you please explain to us why in this preliminary statement it was *x* amount, and why in this follow-up statement you had made a \$6 billion adjustment.

Can you perhaps explain to us and give us the paperwork and the background so that we can understand how this first statement was so totally inaccurate and where the documentation was and why it was not there in the first place, and the answer coming back from the Education Department is no, we do not have the backup data to explain exactly why we needed to make this \$6 billion adjustment.

We found out that in 1998 in the audit that there were \$76.8 million in improperly discharged student loans. These are young people who had received student loans, but the Education Department, rather than expecting these students to repay these loans, had improperly discharged \$76.8 million worth of student loans, a great deal for these students. The problem is, we expected these students, and these students had agreed, to pay us back and the Education Department discharged those student loans. They said well, let it go. These are kids that completed college, not a big deal. It is a big deal. The \$76.8 million could have funded 20,000 new loans for students.

There was \$177 million in improper Pell Grant awards. That is enough for Pell Grants for 88,500 students.

□ 1745

There was \$40 million, and this is one that is very interesting, there was \$40