

ORGAN PROCUREMENT AND
TRANSPLANTATION NETWORK
AMENDMENTS OF 1999

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 454 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 454

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2418) to amend the Public Health Service Act to revise and extend programs relating to organ procurement and transplantation. The first reading of the bill shall be dispensed with. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce. After general debate the bill shall be considered for amendment under the five-minute rule. It shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute recommended by the Committee on Commerce now printed in the bill. The committee amendment in the nature of a substitute shall be considered as read. No amendment to the committee amendment in the nature of a substitute shall be in order except those printed in the report of the Committee on Rules accompanying this resolution. Each amendment may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. All points of order against the amendments printed in the report are waived. The Chairman of the Committee of the Whole may: (1) postpone until a time during further consideration in the Committee of the Whole a request for a recorded vote on any amendment; and (2) reduce to five minutes the minimum time for electronic voting on any postponed question that follows another electronic vote without intervening business, provided that the minimum time for electronic voting on the first in any series of questions shall be 15 minutes. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the committee amendment in the nature of a substitute. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommend with or without instructions.

The SPEAKER pro tempore (Mr. LATOURETTE). The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MOAKLEY),

pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this is a fair, structured rule providing for consideration of H.R. 2418, the Organ Procurement and Transplantation Network Amendments. The rule provides for 1 hour of general debate, equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce. It shall be in order to consider as an original bill for purposes of amendment the amendment in the nature of a substitute recommended by the Committee on Commerce.

No amendment to the committee amendment in the nature of a substitute shall be in order, except for those the Committee on Rules has permitted and printed in the report accompanying this resolution. Each amendment one, may be offered only in the order printed in the report; two, may be offered only by a Member designated in the report; three, shall be considered as read; four, shall be debatable for a time specified in the report; five, shall not be subject to amendment; and six, shall not be subject to a demand for division of the question. The rule waives all points of order against these amendments.

Specifically, the Committee on Rules has provided for the consideration of five amendments dealing with a number of important issues. Finally, the rule provides for one motion to recommend with or without instructions, as is the right of the minority Members of the House.

By way of background, HHS Secretary Donna Shalala announced on March 26, 1998, that the Department would publish in the Federal Register a final regulation that would completely overhaul the organ donor system. The current system, run by the private sector nonprofit Organ Procurement and Transplantation Network, is locally based, allowing patients and their families to search in their communities for a potential donor that could help them. Under the new rules, the system would be nationalized by the Federal Government.

This HHS rule is opposed by the vast majority of the transplant community and a congressional moratorium has been in place for almost 2 years. Clearly, Congress in the past has intended that the Organ Procurement and Transplantation Network, comprised of the medical and scientific community, have the power to allocate organs and decide the guidelines for the contribution of organs.

Today, H.R. 2418, the Organ Procurement and Transplantation Network Amendments, would clearly reinforce our intent that the responsibility for developing medical criteria and standards for organ procurement and transplantation rest with the network. This

legislation also ensures that this distribution of organs is based so equity and ethics without political control or influence and strengthens patient donor data confidentiality safeguards.

One of the most valuable tools we have to raise public awareness about the need for organ donors is through the work of volunteers, dedicated to saving the lives of a particular patient waiting for an organ. If this system is nationalized, the work of these volunteers, while valuable, could not be attributed directly to a particular transplant, but to the next person on a list somewhere in the United States.

The immediate effect that an organ donor could have on his or her community is a primary motivating factor when making the decision to become a donor. These rules go too far in moving organ donation away from the local communities and closer to national bureaucracies. We are opposed to letting political appointees make the decisions to allocate organs across the Nation, and we should not allow a Federal department the ability to impact the medical decisions that affect thousands of patients waiting for a second chance at life.

In addition to ending the politicization of this medical process, we also want to encourage Americans to become organ donors. Because the demand for organs for transplantation far exceeds the supply, we should focus our efforts toward encouraging more individuals to become donors and not spreading the already limited supply of organs even thinner under the HHS nationalization plan.

Unfortunately, reports also indicate that HHS has not effectively done anything to increase organ donations. As a result, H.R. 2418 creates a new \$5 million grant program to pay for the travel expenses incurred by living organ donors, authorizes \$2 million in additional grant funds to carry out studies, and demonstration projects to increase organ donations, and requires the network to work actively to increase the supply of donated organs.

Mr. Speaker, I want to commend the chairman of the Committee on Commerce, the gentleman from Virginia (Mr. BLILEY); and the gentleman from Florida (Mr. BILIRAKIS) for their hard work in crafting this legislation. The product they have crafted would maintain responsible organ transplant policy decision-making within the current network, and this bill should be widely supported by the whole House today.

Mr. Speaker, this rule was unanimously reported by the Committee on Rules yesterday, and I urge my colleagues to support the rule so that we may proceed with debate and consideration of the underlying legislation.

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

Mr. MOAKLEY. Mr. Speaker, I thank the gentleman from Georgia (Mr. LINDER), my colleague and dear friend, for

yielding me the customary half hour. I yield myself as much time as I may consume.

Mr. Speaker, the sad truth is there are not enough body organs to go around. If there were enough organs, the question of whether to give them to the sickest person, or the closest person, really would be moot. But today, this very minute, there are 67,000 people waiting for an organ transplant in the United States alone. Unfortunately, Mr. Speaker, many of them will not receive that organ.

Five years ago, a doctor walked into my hospital room and told me, unless I got a new liver, the chances of me living more than 2 months was a long shot. But I was one of the lucky ones. My life was saved by a liver transplant; and not a day goes by that I do not thank God and medical science for the miracle that happened to me.

So if I thought this bill would expand that miracle to the other 67,000 people waiting for a transplant, I would do all I could to support it. But this bill will not expand the miracle. This bill is being introduced to sabotage the recent HHS regulations, regulations that are supported by the Institute of Medicine, which says that medical professionals should establish organ allocation policies. Those regulations require organs to be given to the sickest patients who might benefit rather than be kept within artificial limits.

In direct opposition to those regulations, this bill will bestow sole authority over life and death decisions upon a private contractor with not one scintilla of regulation. This private contractor will have authority over billions upon billions of dollars of Medicaid and Medicare money. Meanwhile, the public will lose its right to be heard on that subject.

Mr. Speaker, this bill takes the public voice out of public health. It sets back years of progress on organ transplantation policy, and it should be opposed. The rule, however, Mr. Speaker, is fair, and should be supported. The gentleman from California (Mr. DREIER), the chairman of the Committee on Rules and my dear friend, was kind enough to make in order several minority amendments, including the LaHood-Rush-Peterson-Moakley amendment; and for that I thank him.

Five years ago, Mr. Speaker, a family I probably will never meet saved my life. Their son died somewhere in Virginia, and they gave his liver to this Congressman from south Boston. I will never be able to thank them for their kindnesses, but I will be able to keep fighting until every one of those 67,000 other people who need a transplant get one, regardless of where they live.

So I urge my colleagues to support this rule, support the LaHood-Rush-Peterson-Moakley amendment.

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

Mr. LINDER. Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois (Mr. LAHOOD), a sponsor of a major amendment.

Mr. LAHOOD. Mr. Speaker, I thank the gentleman from Georgia (Mr. LINDER) for yielding me this time.

Let me just begin by saying that this is a good rule, and I hope all Members will support it. It is a good rule because it is an open rule and it allows for plenty of debate on this very, very important legislation. As I said in the Committee on Rules last night, there is probably only 1 person in this House who is an expert on transplants, and the importance of a good organ donor program, and that is the gentleman from Massachusetts (Mr. MOAKLEY), the ranking member of the Committee on Rules, who has been through it. He knows the anxiety and frustration, and he knows what it is like to go through a transplant procedure as one who has received a transplanted liver and is, thank God, a survivor and still a good, strong, sturdy, healthy Member of this House of Representatives.

Mr. Speaker, I do support the rule; but I rise in opposition to H.R. 2418, the Organ Procurement and Transplantation Network Amendments of 1999, and in support of an amendment offered by myself and the gentleman from Massachusetts (Mr. MOAKLEY) and the gentleman from Illinois (Mr. RUSH) and the gentleman from Pennsylvania (Mr. PETERSON).

Mr. Speaker, H.R. 2418 is not about saving lives; what it is about is overlooking patients in the greatest need simply because of a geographic convenience. Through Medicare, Medicaid, CHAMPUS and other programs, the Federal Government pays for the vast majority of organ transplants. H.R. 2418 strips the Government of any rule-making authority over transplant policy, affecting thousands of beneficiaries covered under Federal Government programs and delegates it to one agency, one private contractor.

□ 1130

This is wrong. This bill contradicts the recommendations of the Institute of Medicine that are detailed in a report mandated by Congress under the 1998 Omnibus Budget Act.

The IOM recommended additional government oversight of the organ procurement and transplant network and the establishment of an independent scientific advisory committee to work with the government to ensure the efficiency and equitable operation of the OPTN.

H.R. 2418 strips the government of its oversight authority and eliminates all public accountability of the Network. This is wrong.

For these reasons, I urge Members to support the rule but oppose the bill, and support our amendment, the amendment offered by the gentleman

from Massachusetts (Mr. MOAKLEY), myself, the gentleman from Illinois (Mr. RUSH), and the gentleman from Pennsylvania (Mr. PETERSON).

It would apply several recommendations made by the Institute of Medicine to the organ allocation process. It ensures that organ allocation policies are based on sound medical principles and valid scientific data. The policies would be designed to share organs over as broad a geographic area as possible, providing some Federal oversight.

Again, Mr. Speaker, this is a good rule but a bad bill, and I urge my colleagues to support the rule.

Let me just for a minute say something. We do not want to go back to the old ways of doing things. There is a good system in place. This is a bad bill because it goes back to an old system that lets one agency play God about where organs will go. I do not think anybody in America wants that.

I urge all my colleagues and all the staff that are watching this being broadcast around the House system to pay close attention and to call back to their districts, and to talk to hospitals in their districts that do transplants. I doubt if they want one agency, a private agency, in America deciding where organ transplants will take place, this is wrong, with no oversight. Our amendment corrects that.

This is an important amendment, an important consideration for the Congress. I hope people will pay attention to it.

Again, I urge the adoption of the rule, the opposition to the bill, and the adoption of our amendment to bring common sense to a very important medical system in our country that will be eviscerated by this legislation.

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

Mr. Speaker, I thank the gentleman from Illinois (Mr. LAHOOD) for his very, very able presentation. I think he said it all.

Mr. Speaker, I yield 4 minutes to the gentleman from Pennsylvania (Mr. PETERSON), a cosponsor and a gentleman who has been fighting on this for many years.

Mr. PETERSON of Pennsylvania. Mr. Speaker, I rise to support the rule, speak against the bill, and support the amendment.

Mr. Speaker, I think it is important that whenever we are dealing with health care, we follow the lead of health care providers who have studied the issue.

This Congress asked the Institute of Medicine to do that. They did it very seriously and very coherently. They came forth with recommendations that allocation policies should be based on sound medical principles and valid scientific data.

The bill before us veers from that. Whenever we veer from that, we are going to cost lives. I do not think any of us want to be in that position.

Recently, Forbes Magazine talked about this system, UNOS, the united network supplying organs. Most organs are shared only within 62 regional territories, and in their opinion, last year 4,855 Americans died while waiting for transplants. This does not even count people pulled off the lists because they became too sick.

Each of us hopes we never need an organ, but we do not know when we will. We hope that we do not live in the wrong county or in the wrong State that would prevent us from receiving the organ that would save our life. That organ might go to someone who really had serious health problems, but could live a year or two longer.

Mr. Speaker, I hope we devise a system in this long debate today that will make sure that the scarce organs that are available go to those who need them to sustain life and can maintain life after the surgery. Anything less than that, we will have failed the American public.

Mr. Speaker, the other issue I want to raise is that the United Network for Organ Sharing system will under this legislation be totally free of any Federal regulation.

Now, I am not normally a fan of Federal regulators, I am not a fan of Federal power, but I want to tell the Members, we owe it to American citizens that our Federal Government and our HHS and our bureaucracy does oversee everything that deals with health care. We cannot have a system that is totally without some oversight.

Where will the citizens go that were denied? Where will the taxpayers go that are unhappy if we have no Federal oversight of a system?

To show Members what has been going on, patients pay over \$350 to be listed on a waiting list. The listing fees make up the majority of UNOS's budget. They are spending \$1 million a year of their budget to lobby us.

Should an organization that has total control, should an organization that is going to be given a position where they have no oversight, be allowed to spend \$1 million a year to lobby us? No. There are a lot of problems with the system.

I want to say this, in conclusion: Economics should not rule on this issue. Part of this issue is about economics, because parts of this country who are harvesting more organs because they have younger populations and more young people who have good, strong organs that can be transplanted want to keep them there.

It is economics, health care economics. It is still one of the profitable parts of health care, and there are not many. I think that should not be part of this system. I think each and every one of us and each and every one of our constituents and taxpayers should have the thought and the hope that, just like they expect good emergency care

no matter where they live, they would expect an equal chance at an organ if life depended on it.

Mr. MOAKLEY. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. STARK), the ranking member on the Subcommittee on Health on the Committee on Ways and Means.

Mr. STARK. I thank the distinguished ranking member for yielding time to me, Mr. Speaker.

Mr. Speaker, I rise to discuss the legislation before us, and strongly oppose the legislation. It will really do harm. There are 66,000 Americans now awaiting organ transplants. Thirteen people die every day waiting.

H.R. 2418 does not save lives. The bill is very bad health policy. It impedes the public access to lifesaving information. It provides a monopoly and unprecedented protections to the current private contractor, which I might add Forbes Magazine characterized as an outfit with life and death power over patients waiting for transplants, and it has evolved into a heavy-handed private fiefdom.

It removes itself from public accountability by delegating an improper amount of regulatory power and control over billions of taxpayer dollars. It gives it to a private contractor, which the Department of Justice considers unconstitutional. It contradicts the congressionally-mandated National Academy of Sciences' Institute of Medicine recommendations, and it is something which we should oppose.

Mr. Speaker, there is some small hope in the LaHood-Moakley-Rush-Peterson amendment which will be offered, and I ask my colleagues to support that amendment, which makes the data available to the public. It ensures broader sharing of organs and organ allocation decisions on medical necessity versus just the accident of geography. It provides a public accountability through Federal oversight. It does not squirrel away these decisions in the back rooms of private enterprise.

It establishes a scientific advisory board separate from this private organ contractor, and it would, indeed, make some small effort to make the bill before us more equitable and a more humane bill which would provide good health policies.

So please support the LaHood-Moakley-Rush-Peterson amendment, and oppose H.R. 2418 at final passage.

Mr. Speaker, more than 66,000 Americans currently await an organ transplant. Every day 13 people die waiting for an organ.

H.R. 2418 does not save lives. This bill is bad health policy.

Instead, H.R. 2418—Impedes public access to life saving comparative information about transplant centers.

Provides a monopoly and unprecedented protections to the current contractor (UNOS—the United Network for Organ Sharing) which Forbes magazine characterized as “an outfit with life-and-death power over patients waiting

for transplants [that] has evolved into a heavy-handed private fiefdom”.

Removes public accountability by delegating an improper amount of regulatory power and control over billions of taxpayer dollars to a private contractor—which DOJ considers unconstitutional.

Contradicts the Congressionally mandated National Academy of Science's Institute of Medicine (IOM) recommendations.

Protects special interests—plus those of both UNOs—with their headquarters in Representative BLILEY's district, and plus those of the transplant centers that fear decreased business or that their centers will close under a fairer system or broader organ sharing.

Mr. Speaker, the Scarborough/Thrumman amendment nullifies the final organ allocation regulation published by the Secretary of Health and Human Services.

The Secretary published the final rule governing the organ procurement and transplant network (OPTN) on April 2, 1998. After 2 years of congressional delays, this regulation became effective last month.

The HHS regulation calls for more equitable sharing of too-scarce supply of organs and over much larger populations of people who need them.

As the final regulation states, it “does not establish specific allocation policies, but instead looks to the organ transplant community to take action to meet the performance goals”—a rule that the Washington Post today notes is “Hardly Draconian.”

HHS oversight ensures that allocation policies are developed with the expertise and experience of patients and medical practitioners. When those allocation policies fail to achieve the ends envisioned by Congress—as is the case today—the Secretary can ensure these failures are corrected.

The final rule has been supported by the major transplant patient organizations, including the American Liver Foundation, Transplant Recipients International Organization and the National Transplant Action Committee.

However, the extent to which a government contractor has attempted to influence and undermine the legislative and regulatory processes is alarming. UNOS has spent patient listing fees on a lobbying and public relations smear campaign. UNOS' numerous efforts to derail the final rule have diminished public confidence in the organ allocation system.

Mr. Speaker, this amendment incorporates IOM recommendations to establish a fairer national organ allocation policy and to—make comparative data widely available to the public. Ensure broader sharing of organs and base organ allocation decisions on Medical Necessity vs. Accidents of Geography. Provide public accountability through Federal oversight. Establish a scientific advisory board, separate from the private organ contractor.

The current system has created great disparities in organ allocation and transplantation outcomes.

Last fall, HHS publicized comparative transplant center performance data showing that under the current organ contractor's policies, a patient's chance of receiving an organ transplant depends on geography, not on medical need. For example:

In some areas of California, patients had a 71 percent chance of receiving a liver transplant within one year, whereas patients had

only a 24 percent of receiving a liver transplant in other areas of the State.

In December 1999, the *New England Journal of Medicine* concluded that liver-transplantation centers in the U.S. that perform 20 or fewer transplantations per year have significantly higher mortality rates than those centers that perform more than 20 transplantations per year. This life-saving data must be widely available to the public. This amendment would ensure it is.

CONCLUSION

Our Nation's system must base transplant decisions on common medical criteria and pure professional medical opinion—not geography. Donated organs go to those with the most medical need.

Without the LaHood-Peterson-Rush-Moakley amendment, H.R. 2418 will permit these inequities and cause additional, needless deaths.

Knowing that a loved one's or your own organ will go to the patient who needs it most will help improve donation rates—something our Nation very much needs and one thing that everyone can agree on.

Most all of us are aware of the problem: the demand for organs exceeds the supply—ensuring fair allocation of these scarce organs even more important.

Unfortunately, H.R. 2418 is not the answer.

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

Mr. Speaker, I would just like to bring the Members' attention to an article in today's *Washington Post* titled, on the editorial page, "New Round of Transplants."

If I may read just from a portion of it, they say, "The strange battle over who will control the distribution of transplanted organs continues to rage. The House is scheduled to vote today on an ill-advised bill to strip the Department of Health and Human Services of authority to set rules for the private contractors that manage the nation's transplants. This comes 18 days after an HHS regulation aimed at achieving more consistent and equitable policies finally went into effect after 2 years of heated opposition from the transplant network and its members."

"The HHS rule is hardly draconian. It merely calls on the United Network of Organ Sharing, UNOS, to develop policies that better spread the too scarce supply of transplantable organs over the much larger population of people who actually need them. Right now, each distribution center has its own waiting list, creating dramatic disparities in which organs often fail to reach those with the most urgent need."

"But many local transplant centers are fiercely territorial and fear losing business to a few large transplant centers at major hospitals. Since the HHS rule was proposed, nearly a dozen States have passed laws forbidding organs to be sent to recipients out of state; Wisconsin is suing to block a feared outflow to nearby Chicago. The national network, meanwhile, has sev-

eral times persuaded Congress to put off the rule. Congress also commissioned a report from the Institute of Medicine, which made proposals similar to those of HHS."

Mr. Speaker, I include this entire article for the RECORD.

The article referred to is as follows:

[From the *Washington Post*, Apr. 4, 2000]

NEW ROUND ON TRANSPLANTS

The strange battle over who will control the distribution of transplanted organs continues to rage. The House is scheduled to vote today on an ill-advised bill to strip the Department of Health and Human Services of authority to set rules for the private contractors that manage the nation's transplants. This comes 18 days after an HHS regulation aimed at achieving more consistent and equitable policies finally went into effect after two years of heated opposition from the transplant network and its members.

The HHS rule is hardly Draconian. It merely calls on the United Network for Organ Sharing (UNOS) to develop policies that better spread the too-scarce supply of transplantable organs over the much larger population of people who need them. Right now, each distribution region has its own waiting list, creating dramatic disparities in which organs often fail to reach those with the most urgent need.

But many local transplant centers are fiercely territorial and fear losing business to a few large transplant centers at major hospitals. Since the HHS rule was proposed, nearly a dozen states have passed laws forbidding organs to be sent to recipients out of state; Wisconsin is suing to block a feared outflow to nearby Chicago. The national network, meanwhile, has several times persuaded Congress to put off the rule. Congress also commissioned a report from the Institute of Medicine, which made proposals similar to those of HHS.

A pending Senate bill would incorporate those recommendations. The House bill would simply vaporize the HHS rule in favor of the prior system. The House should drop the effort and follow the Senate's lead.

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

Mr. Speaker, I urge support for a rule that made every effort to include all the serious discussion around this bill. This is a very important bill. All the issues that were brought before the committee have one way or another been allowed to be discussed and voted up-or-down on the floor.

I urge my colleagues to support the rule.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to House Resolution 454 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2418.

□ 1143

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole

House on the State of the Union for the consideration of the bill (H.R. 2418) to amend the Public Health Service Act to revise and extend programs relating to organ procurement and transplantation, with Mr. LATOURETTE in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Virginia (Mr. BLILEY) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Virginia (Mr. BLILEY).

□ 1145

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in support of H.R. 2418, the Organ Procurement and Transplantation Network Amendments of 1999. It has been 2 years and 2 days since the Clinton administration issued its regulation on the Organ Procurement and Transplantation Network. Some claim that the regulation changed the HHS Secretary's oversight authority into a policymaking authority. Policy control of the network is not what Congress has ever intended and that is not what the law permits. The Organ Procurement and Transplantation Network was authorized by Congress to make decisions without political interference.

The decisions they make safeguard the interests of not just those who are presently on a waiting list for a life-saving organ but those unknown persons who will be placed on a waiting list in the future.

Mr. Chairman, H.R. 2418 would safeguard the independence of the network. It would also increase the level of accountability of the network by mandating timely reports on the performance of transplant centers within the network.

The bill includes an innovative enforcement mechanism that would mandate the payment of liquidated damages by transplant centers that try to cheat under the network rules.

I also applaud the provision that would offer assistance for living donors seeking to donate an organ to someone in another State.

H.R. 2418 will ensure that decisions regarding organ procurement are placed in the hands of the medical community, patients and donor families, as they have been for the past decade. The creation of a national registry, where organs are allocated to the sickest patients first, would increase wait list mortalities, waste organs and increase retransplantation rates.

The Federal Government is simply not equipped to make these decisions. The Institute of Medicine reported that the current system is basically fair. It achieves a balanced and fair distribution of organs for all who await a life-saving transplant while supporting the

continuation of local transplant programs.

As we move forward to reauthorize the National Organ Transplant Act, let us not forget that some alternatives to this bill may have a very damaging effect on organ supplies. According to written testimony submitted to the Subcommittee on Health and Environment, Joseph L. Brand, chairman of the National Kidney Foundation stated that, and I quote, "we believe that less patients would receive liver transplants if the OPTN were required to develop policies where organs are allocated to the sickest candidates first. Such candidates are likely to have poor outcomes and require repeat transplants. Thus, reducing the number of organs available for other candidates," unquote.

I urge Members of the House to join with me in voting for H.R. 2418 to safeguard those who wait for an organ transplant from even more uncertainty.

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

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, today we are taking up H.R. 2418, legislation sponsored by my friends, the gentleman from Florida (Mr. BILIRAKIS), the gentleman from Texas (Mr. GREEN), which would reauthorize and amend the National Organ Transplant Act.

House leadership has decided to move this controversial measure even though the Senate is making real progress on legislation reflecting consensus between those who oppose and those who support H.R. 2418. Surely it is more important to get this legislation right than it is to get our two cents in before the Senate does. Yet here we are poised to vote on a measure that while promising should not be passed whole cloth.

In its current form, the President would likely veto H.R. 2418 or the courts would likely dismiss the legislation as unconstitutional. There are some beneficial aspects to H.R. 2418. One set of provisions would help States pay for transportation and other costs incurred by organ donors. Given the waiting list for donated organs, anything we can do to facilitate organ donation is certainly a positive step.

Unfortunately, though, Mr. Chairman, omitted from this bill are several key recommendations that the Institute of Medicine made after taking a close look at the current organ allocation system. The most alarming omission is not really an omission as much as it is a gift. It is a gift to the United Network for Organ Sharing, so-called UNOS, the private contractor managing the current organ allocation system. H.R. 2418 gives UNOS a virtual carte blanche to spend taxpayers' money and determine which individuals will receive donated organs and

which individuals will not receive donated organs.

Under H.R. 2418, UNOS would have carte blanche to spend our money and to make these life and death decisions without taking the public views into account. As currently written, 2418 confers more power on UNOS than it does on its employer, and its employer happens to be the American taxpayer.

2418 undercuts the authority of the Secretary of the Department of Health and Human Services to represent the public interests in the development and the application of organ allocation policies. In other words, the public would have no say over public policy.

The Secretary's job is to protect and promote the public interest and our public health. The contractor, UNOS, the contractor's job is to protect and promote itself. Last year the Institute of Medicine took a good hard look at the Nation's organ allocation system and made several compelling recommendations. One of those recommendations was that the Federal Government must exercise more oversight over the organ allocation system to ensure that individuals in need of donated organs are treated fairly.

This bill, Mr. Chairman, goes in the opposite direction. I understand my colleagues, the gentleman from Illinois (Mr. LAHOOD), the gentleman from Massachusetts (Mr. MOAKLEY), the gentleman from Illinois (Mr. RUSH) and the gentleman from Pennsylvania (Mr. PETERSON) will offer an amendment that would incorporate those Institute of Medicine recommendations into H.R. 2418, improving the bill measurably, recommendations like ensuring independent scientific review of organ allocation policies; of ensuring that organ allocation decisions are based on sound medicine and sound science; and ensuring that organ allocation decisions are equitable to people in this country; and ensuring that the Federal Government does its job and holds the Government contractor who works for taxpayers accountable for acting in the public's best interest. I strongly urge my colleagues to vote for this amendment.

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

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Chairman, I rise in support of H.R. 2418 because it keeps a promise made by Congress for the past 16 years to safeguard the independence of the Organ Procurement and Transplantation Network from political interference and control.

Ever since the National Organ Transplant Act of 1984 was enacted, Congress has recognized that experts at the forefront of changes in the medical profession and transplant community are best suited to adjust allocation policies in light of new technologies and new medical understanding.

Do we really want Federal bureaucrats making decisions about who gets these organs? What will keep the decisions being made from being political ones?

The congressionally created Organs and Transplant Network has worked, and it has worked in a nonpolitical way. The LaHood amendment, while well intentioned, would result in taking medical policy decisions out of the hands of doctors and placing them in the hands of bureaucrats. Medical decisions about organs are better left in the hands of health care professionals and transplant centers. That was the intent of the law when it was created in 1984 and remains so today.

Please join me in supporting H.R. 2418.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Wisconsin (Mr. BARRETT), a member of the Committee on Commerce.

Mr. BARRETT of Wisconsin. Mr. Chairman, I rise today in strong support of H.R. 2418, and I say strong support even though I recognize that it is an imperfect solution to what I consider to be a horrible problem.

We have a serious problem in this country because the demand for organs is much greater than the supply, and there are essentially two ways to deal with that problem. One is for those areas of the country that feel that they do not have enough organs to essentially raid other parts of the country and try to grab those organs. The second option, and the option that I strongly prefer and I will have an amendment later addressing this, is to be aggressive and work together to increase the supply of organs. The problem with the Department's rule is that it defies the laws of economics. It assumes that economics is not involved in this fight when the reality is economics is at the core of this fight.

These are hospitals, these are businesses, big businesses, that are fighting over organs because organs, unfortunately in this context, equate with money. So there are situations like my State of Wisconsin that will see an essentially 30 percent drop in the number of organs available to them and my neighboring State of Illinois seeing a 30 percent increase.

Now, Chicago is 100 miles from Milwaukee, and it would not be that difficult for these patients to come to Milwaukee; but instead of trying to work together, what we see is we see from Wisconsin's perspective a raid, a raid on the fine job that we have done in Wisconsin to try to encourage more people to donate their organs. It defies logic to state that those areas of this country that have done a very good job, including my home State of Wisconsin, in developing an organ procurement network are going to continue working as hard as they have if they

are going to see those organs leave the State.

We have to recognize some basic tenets of human nature; and one of those is, if one is allowed to keep the fruits of their labor, they are going to work harder. If the fruits of their labor are going to be sent to another part of this country, that increases the chances that they will not work as hard.

So I think that this bill, again, is an imperfect bill; but I think that the Department's response is in exactly the wrong direction.

Mr. BLILEY. Mr. Chairman, I yield 3 minutes to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Chairman, I think it is important that we have a little perspective on why we are where we are. There is no question that this country had three or four major transplant centers that developed and perfected a lot of techniques, and then they asked doctors to come and offer their services for free to learn those techniques.

Know what? They did, and there are throughout this entire country now highly qualified, highly trained transplant surgeons in every State in the country.

Guess what happened? Now that they are as good as the transplant centers, the major transplant centers that pioneered this work, they are doing more transplants and all of a sudden the major centers do not have the organs with which to transplant because the people are being transplanted at home.

The purpose of this bill is to offset what I believe is a very unwise rule by Secretary Shalala. What this rule that is undergoing implementation as we speak will do will limit people in the outreaches of this country as far as transplants. They will have to live in an urban center, or they will have to move with their family to that urban center to achieve this.

This totally obviates the decision-making by health care professionals and their patients and puts bureaucrats in charge.

The HHS regulations are only going to shift organs around, and I think that is the important thing that needs to be noted. The real problem, this would not be a problem if there were an excess number of organs, and what it is going to do is the HHS rule defines the sickest patients as those that have been waiting the longest. They are not necessarily the truly sickest patients. So we are going to displace common sense, we are going to displace care and compassion, we are going to displace regional geographic quality and move organ transplantation back to the original centers of excellence when, in fact, the scientific studies say that the competing centers that they trained are doing as well or better in many instances.

In my home State of Oklahoma we have two centers of excellence for

transplantation now, all of which received their training at one of these major pioneering centers. The fact is, the results are as good or better than those centers.

The other thing is, Oklahoma developed an organ donating network where we actually have an excess supply in our State now, more organs than what our citizens would supply. With this new rule, Oklahomans will not have the benefit of organs donated by their fellow citizens to another Oklahoman. Instead, a bureaucrat, influenced through the organization that the Secretary already controls, will then decide that people who offered the organs for donation will not benefit their fellow citizens.

I would ask that we support this bill and that the House come behind common sense and quality medicine.

Mr. BROWN of Ohio. Mr. Chairman, I yield 3 minutes to my friend, the gentleman from Illinois (Mr. LAHOOD).

Mr. LAHOOD. Mr. Chairman, let me see if I can explain to the House what is going on here. We have a pretty good system now, and there is pretty good oversight. If we pass this bill today, we let one agency play God with transplants and where organs will go. I do not think anybody in America wants one group to decide where all the organs are going to go. We just do not. That is bad policy, with no oversight, no government oversight.

This notion that some bureaucrat is going to make the decision is nonsense. It is not going to happen. There was actually a study done that said that there should be some oversight so that one agency cannot play God about where organs should go.

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If we talk to any family about the long waiting list, the anxiety, the frustrating, they will tell us that one agency should not have this opportunity.

There is a letter that I have here from the agency, the United Network of Organ Sharing. This is the agency that has the jurisdiction right now over this. Let me just read the first paragraph. This is a letter to the gentleman from Michigan (Mr. DINGELL).

This letter is dated March 15. It says, "On behalf of the Board of Directors of UNOS, I am very pleased to inform you and the members of the Committee that Monday we approved a new and expansive National Liver Allocation Policy Development Plan. Clearly, this plan goes a long way in furthering UNOS' and the Department of Health and Human Services' mutual goal of fair and equitable organ distribution. In addition, UNOS and HHS are working closely together to ensure an effective and efficient implementation of Department's Final Rule set for March 16th, including its organ allocation provisions."

Mr. Chairman, I include the March 15, 2000, letter and the Statement of

Administration Policy for the RECORD as follows:

UNITED NETWORK FOR
ORGAN SHARING,

Richmond, VA, March 15, 2000.

Hon. JOHN D. DINGELL,

Ranking Minority Member, House Committee on
Commerce, Washington, DC.

DEAR CONGRESSMAN DINGELL: On behalf of the Board of Directors of the United Network for Organ Sharing (UNOS), I am very pleased to inform you and the members of the Committee that Monday we approved a new and expansive National Liver Allocation Policy Development Plan. Clearly, this plan goes a long way in furthering UNOS' and the Department of Health and Human Services' mutual goal of fair and equitable organ distribution. In addition, UNOS and HHS are working closely together to ensure an effective and efficient implementation of the Department's Final Rule set for March 16th, including its organ allocation provisions.

Our new Liver Allocation Policy Development Plan was produced after a series of joint meetings of the UNOS Liver and Intestinal Organ Transplantation Committee and the UNOS Pediatric Transplantation Committee. The Committees incorporated recommendations from the Institute of Medicine report on Organ Procurement and Transplantation as well as many thoughtful public comments. We genuinely believe that the resulting policy, after further refinement at a scheduled consensus conference of the transplant community on liver allocation, will reflect the principles and goals of the Secretary's Final Rule and fully represent the transplant community's interests in developing equitable and medically sound policies.

Major elements of the proposal include a plan for significantly refining urgency categories for Status 2A, 2B and 3 liver transplant candidates by implementing a new numerical scale which will more accurately represent the varying degrees of illness among these patients. We are also endeavoring to better predict pre- and post-transplant mortality and morbidity in order to make the most efficient use of the previous livers that do become available. Further, we will establish appropriately-sized organ allocation units for all organs, and improve policy compliance monitoring by implementing a system for prospective verification of liver patient listing and status code changes.

We are proud of the efforts of the many medical professionals from the transplant community who joined together to develop this new important policy plan.

We would like to thank you and the Committee members for your continued interest and support for the life-giving endeavor of organ and tissue transplantation.

Sincerely,

WILLIAM D. PAYNE M.D.,
President.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT
AND BUDGET,

Washington, DC, April 3, 2000.

STATEMENT OF ADMINISTRATION POLICY

H.R. 2418—ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK AMENDMENTS OF 2000

The Administration strongly opposes House passage of H.R. 2418, which would reauthorize the National Organ Transplantation Act (NOTA). H.R. 2418 raises serious Constitutional issues, would preserve existing inequities in the organ transplantation system, and could result in potential harm

to patients. If H.R. 2418 were presented to the President in its current form, his senior advisers would recommend that he veto the bill.

The effects of the current organ allocation policies established by the Organ Procurement and Transplantation Network (OPTN) are inequitable because patients with similar severities of illness are treated differently, depending on where they may live or at which transplant center they may be listed. For this reason, the Department of Health and Human Services issued regulations, which became effective March 16th, that establish a framework for organ allocation policies, to be developed by the network, that are based on sound medical judgment, and that are fairer and more equitable for all parties. Unfortunately, H.R. 2418 would not result in a fairer system for all patients in this country. Rather, it is seriously flawed legislation because it:

Does not require the standardization of patient listing practices and broader sharing of organs, two items that the Administration and the Institute of Medicine consider essential to ensuring fairness in the system and optimal outcomes for patients.

Reduces the appropriate Federal role in overseeing the OPTN, despite the recommendation from an independent study required by Congress and conducted by the prestigious Institute of Medicine, that HHS should have the oversight responsibility "to manage the system of organ procurement and transplantation in the public interest, and to ensure public accountability of the system."

Inappropriately grants extraordinary powers to the private sector to approve the Federal contractor that manages the OPTN.

Raises serious constitutional concerns. It is a core constitutional value that politically accountable Executive Branch officers should make the important policy judgments necessary to implement a Federal regulatory scheme. For this reason, the bill's delegation of authority to a private party to establish standards governing organ transplants and transplant providers raises serious separation of powers concerns and would create a significant risk that a court might declare the bill unconstitutional.

The Administration could support the amendment offered by Representatives LaHood, Moakley, Rush, Peterson (John) and others. Similar to the current regulation, it reflects the recommendations made by the Institute of Medicine in its Congressionally mandated study of organ allocation policies and it strikes the proper balance between medical judgments being made by transplant professionals and the need for public accountability for tax payer funds. It articulates clear principles to guide organ allocation policy, designed to protect the interests of patients. It assures that data necessary to evaluate and improve the organ transplant system are provided to the public. It avoids the serious constitutional problems that are raised with H.R. 2418. Further, it promotes organ donation, the single most important factor in dealing with the shortage of transplantable organs. In sum, if Congress determines that legislation to update the National Organ Transplant Act is desirable, the amendment offered by Representatives LaHood, Moakley, Rush, Peterson (John) and others represents a thoughtful legislative response.

The Administration urges the Congress to develop NOTA reauthorization legislation that better reflects the recommendations of the Institute of Medicine and that results in

a fairer transplantation system for all patients in this country and their families.

Mr. Chairman, so what we have got on the floor today is a bill in spite of the fact that these two agencies, HHS and UNOS, are working together. Congress is going to say, well, the heck with that, we want to give it to one agency. We want to tell families all over America that one agency gets to play God.

Now, here is what happens if this bill passes. We go back to the Mickey Mantle mentality of organ transplants. If one is somebody important, if one has a high profile, if one is an important person in America, one gets the organ. If one is just a common, ordinary citizen, one agency decides it. That is wrong.

We should not be administering health care, passing laws that distribute organs in this kind of a fashion in America. We have got a system whereby the Department of Health and Human Services will have oversight.

So what I am saying today is we have got an amendment, it is a good amendment, offered by the gentleman from Chicago, Illinois (Mr. RUSH), the gentleman from Massachusetts (Mr. MOAKLEY), the gentleman from Pennsylvania (Mr. PETERSON) that simply says that HHS should have some responsibility.

Mr. BLILEY. Mr. Chairman, will the gentleman yield?

Mr. LAHOOD. Absolutely. I am happy to yield to the gentleman from Virginia.

Mr. BLILEY. Mr. Chairman, can the gentleman from Illinois name me one instance where a person got an organ out of order.

Mr. LAHOOD. Yes, Mr. Chairman, I can. If the gentleman from Virginia (Mr. Bliley) will yield me 2 minutes, we will proceed.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Illinois (Mr. LAHOOD).

Mr. LAHOOD. Mr. Chairman, I go back to the notion that there have been high-profile people who have been given organ transplants out of order, and I mentioned one already.

Mr. BLILEY. Mr. Chairman, if the gentleman will yield, Mickey Mantle did not get his organ out of order.

Mr. LAHOOD. Mr. Chairman, everybody in America knows that there are long waiting lists for these organs, long waiting lists. People wait years, and sometimes they die before they get their organs. But if one is a high-profile person, perhaps one moves up on the list.

We have a good system in place, and that system says we have got the agency, but we also have got jurisdiction from a Federal agency that deals out the money.

Who protects the taxpayers in these instances? Does one agency just happen to have the responsibility, and the taxpayers are not protected? What is

wrong with having HHS as a part of the responsibility to oversee? We do it in all other areas. Can the gentleman from Virginia explain to me why we would not do it?

Mr. BLILEY. Mr. Chairman, I yield 5 minutes to the gentleman from Florida (Mr. BILIRAKIS), chairman of the Subcommittee on Health and Environment.

Mr. BILIRAKIS. Mr. Chairman, I thank the gentleman from Virginia for yielding me this time.

Mr. Chairman, the gentleman from Illinois talks about one agency. One Department I guess is okay, but one agency is not okay. I am not sure really what agency he is referring to.

I introduced this bill with the gentleman from Texas (Mr. GREEN) to reauthorize the National Organ Transplantation Act and to promote efforts to increase the supply of organs available for transplantation. The bill was passed by the subcommittee and then later on by the full Committee on Commerce approved by voice vote in October.

I was here when the gentleman from Massachusetts (Mr. MOAKLEY) made the comments that this bill intends to strip HHS of its authority. Well, I am here to say to the gentleman that this bill actually will leave the status quo alone. The HHS does not have the authority. It is HHS which is trying to strip the authority away from the States, if you will, and from the network and from the regions.

It was HHS, despite the fact that everything has been working and working well, that chose to take organ allocations away from the medical community and from the patients and from the donor families, as Congress intended.

Now, there has been testimony in hearings and whatnot, and there is an article in the Washington Post back in 1996 about a particular person, and I wish the gentleman from Illinois (Mr. LAHOOD) would listen to this, a particular individual, a Pittsburgh real estate agent who has real estate and property management dealings with the University of Pittsburgh Medical Center. He is also, as I understand it, a very close friend, this comes from the Post now, I am paraphrasing, of President Bill Clinton since their days at Georgetown. Okay.

The university apparently, according to the Post, asked this person to intercede with administration regarding this particular issue because they were afraid that they had a genuine reluctance, to use the words in the Post's article, to get involved. According to the Post, this September 30 letter got results.

According to these and other reports, President Clinton directly raised this issue with Secretary Shalala; and in November, she wrote Mr. So and So, explaining the Department would hold hearings or look into this situation.

According to Transplant News, October 31, 1996, which is a commercial news letter of the transplant community who wrote this letter, the letter clearly represents the arguments of the University of Pittsburgh Medical Center.

I want to say right now the University of Pittsburgh is my alma mater. When they are right, they are right. When they are wrong, they are wrong.

The article goes on to state, this gentleman outlined the University of Pittsburgh Medical Center's position that livers should be allocated "to the sickest patients in the largest possible geographic area where the organ can be transported and remain in good condition to be transplanted."

I think we have to ask ourselves, is the Government, is this bureaucracy up here equipped to make these decisions? Do we want the Government, the same administration which determined who should be buried in Arlington Cemetery as a result of politics, do we want politics determining life and death matters? I think not. I think not.

The bill directs the Secretary to carry out a program to educate the public with respect to organ donation and, in particular, the need for additional organ transplantation.

The bill acknowledges the advances of medical technology that have enabled a transplantation of organs donated by living individuals to become a viable treatment option for an increasing number of patients.

It reauthorizes the act which was enacted to provide for the establishment and operation of a network, and the bill clarifies that the network is responsible for developing, establishing, and maintaining medical criteria.

Mr. Chairman, these experts are at the forefront of changes of the medical profession. The gentleman from Oklahoma (Mr. COBURN) referred to them. They said in the American Society of Transplant Surgeons letter last year, and I quote them, "an important step forward," referring to this bill, "in setting forth principles to guide the functioning of a fair and equitable Organ Procurement Transplantation and Transplantation Network in the 21st Century."

The question of how to allocate a limited supply of organs among individuals in need of a transplant is extremely serious with life or death consequences, as I have already said, for the patients affected. Their lives should not be subject to the whims of the political process or the judgments of government bureaucrats with little or no experience in the field of transplantation.

We also should remember that many States, my State of Florida, Texas, so many others, have very successful programs to encourage organ donation; and those have been developed at the State level.

So there is an incentive to say to a fellow Floridian or fellow Texan or whatever the case may be that your organ will in all probability be used in this State or in this particular region, provided that there is a category 1 or category 2 patient that needs the particular organ. Of course it will be moved to another region if, in fact, there is not.

The program in Florida operated by LifeLink has increased donations by almost 50 percent in the last 3 years alone. We cannot interfere with that.

Mr. Chairman, I stand before you today to ask my colleagues to join me in supporting passage of H.R. 2418, the "Organ Procurement and Transplantation Network Amendments of 1999."

I introduced this bipartisan bill with Congressman GENE GREEN to reauthorize the National Organ Transplantation Act and promote efforts to increase the supply of organs available for transplantation. H.R. 2418 was passed by my Health and Environment Subcommittee last September, and the full Commerce Committee approved the bill by voice vote in October.

This legislation addresses a serious national health concern. Quite simply, we do not have enough organs to satisfy the demand for those in need of a transplant.

By even the most optimistic estimates, anticipated increases in organ supply are not projected to meet demand. This year, about 20,000 people will receive organ transplants—but more than 40,000 will not. In the last decade alone, the waiting list for transplants grew by over 300 percent. This is literally a matter of life and death for tens of thousands of Americans each year.

My bill directs the Secretary of Health and Human Services to carry out a program to educate the public with respect to organ donation and, in particular, the need for additional organs for transplantation.

The bill acknowledges the advances in medical technology that have enabled the transplantation of organs donated by living individuals to become a viable treatment option for an increasing number of patients. It specifically recognizes the generous contribution made by each living individual who has donated an organ to save a life. It also authorizes grants to cover the costs of travel and subsistence expenses for individuals who make living donations of their organs.

In addition, H.R. 2418 reauthorizes the National Organ Transplant Act, which was enacted to provide for the establishment and operation of an Organ Procurement and Transplantation Network. The bill clarifies that the Network is responsible for developing, establishing and maintaining medical criteria and standards for organ procurement and transplantation.

Mr. Chairman, those experts at the forefront of changes in the medical profession are best suited to adjust policies in light of new technology and medical understanding. In a letter last year, the American Society of Transplant Surgeons (ASTS) identified the bill as "an important step forward in setting forth principles to guide the functioning of a fair and equitable Organ Procurement and Transplantation Network in the 21st Century."

This legislation recognizes that decisions regarding organ procurement and transplantation are best left to the medical community—as Congress intended in passing the National Organ Transplant Act in 1984. It will ensure that organs are distributed based on sound scientific principles—without regard to the economic status or political influence of a recipient.

The question of how to allocate a limited supply of organs among individuals in need of a transplant is extremely serious—with life-or-death consequences for the patients affected. Their lives should never be subject to the whims of the political process or the judgments of government bureaucrats with little or no experience in the field of transplantation.

This point was reinforced by a letter I received last year from Kathy Gibson, a 49-year-old constituent who received two kidney transplants in one year. The second transplant, which was a success, followed an unsuccessful first transplant using her husband's kidney. Kathy received her second kidney through LifeLink Foundation, a nonprofit community service entity in Tampa, Florida, that operates four of the nation's 62 organ procurement organizations. She wrote to tell me how grateful she was for LifeLink's assistance, saying: "I have nothing but good things to say regarding my transplant team from Tampa General Hospital and LifeLink Transplant Institute . . . they found me the gift of life."

H.R. 2418 was drafted with people like Kathy Gibson in mind. By promoting efforts to increase organ donation around the country, it will help ensure that there is an adequate supply of organs for every patient who needs a transplant.

We should remember that many successful programs to encourage organ donation have been developed at the state level. In my home state of Florida, the organ procurement program operated by LifeLink has increased donations by almost 50 percent in the past three years alone. Organ allocation policies should not penalize states like Florida that have worked hard to increase the supply of organs available for transplantation. Instead, we should encourage other states to become more pro-active in support of organ donation initiatives.

To aid those efforts, H.R. 2418 authorizes the Secretary to establish a public education program to raise awareness of the need for organ donations. It also authorizes grants to public and nonprofit private entities to conduct studies and demonstration projects focused on providing for an adequate rate of organ donation.

Mr. Chairman, H.R. 2418 represents an important step forward in increasing the supply of organs available for transplantation. I urge all of my colleagues to support passage of this critical measure.

Mr. BROWN of Ohio. Mr. Chairman, I yield 5 minutes to the gentleman from Michigan (Mr. DINGELL), ranking member of the Committee on Commerce and the Dean of the House.

Mr. DINGELL. Mr. Chairman, I thank the gentleman from Ohio for yielding me this time. Mr. Chairman, I rise in opposition to H.R. 2418, and I urge my colleagues to vote against this

bill and to vote for the Moakley-LaHood amendment. That will give us a decent proposal.

This bill is founded on deceit, misrepresentation, and falsehood by a rather shoddy, shabby contractor who seeks an absolute monopoly over the handling of organs in this Nation and which seeks as contractor to be totally exempt from the controls that the Federal Government would impose on any other contractor. In addition to that, it seeks to have itself fixed in a position where it can never be replaced. That is what is at the bottom of this bill. Anybody who does not know that is not a very good reader of legislation.

Now, having said that, let me tell my colleagues something else. UNOS, which is the contractor, seeks to use a rather unfortunate situation where there is a shortage of organs to put themselves in a place where they can now dictate to the whole Nation. This situation with regard to organs is a very bad one. There is wide disparity in availability of organs in different parts of this country. People are dying because of that situation. Healthy people are getting organs before they need them, and the very sick are not getting organs before they die. If my colleagues like that situation, this is a bill that they should support. If they do not, then they have no choice but to oppose it.

The organ procurement legislation before us is nothing more or less than a perpetual employment and protection from public oversight act to take care of UNOS. Now, while the bill has a few worthy provisions, H.R. 2418 perpetuates an allocation system that the Secretary of Health and Human Services has found to be inequitable and inefficient. African Americans, for example, wait twice as long for kidneys as Caucasians. Is this something which encourages organ donation? I think not.

H.R. 2418 will return us to the days before the National Organ Transplant Act was enacted in 1984. The organ allocation system was a balkanized patchwork of regions based on political and geographical considerations as well as amorphous understandings. The map of these regions makes gerrymandered congressional districts look not only fairly neat, but also elegant by comparison.

This legislation, as I said, would strip HHS of virtually all authority. It leaves UNOS totally in charge of the organ allocation system. It is in contrast and in open conflict with a number of State statutes. No one believes that a situation of allocation based on State boundaries is in the best interest of the patients. But that is what we will be left with if H.R. 2418 is enacted, with all of the hardships that that will entail for people who are dependent on organ transplants for life itself.

It also puts UNOS on top of HHS. The contractor will be dictating to the Gov-

ernment and in a fashion which, very frankly, does not represent the best interests of the public. In so doing, it allows State hoarding laws to trump even UNOS's version of broader sharing.

So if my colleagues want to take care of the sick and the needy and those who need organs, then they must vote against this legislation.

Now, notwithstanding the Organ Transplant Act's clear directive to promote a more fair and efficient national organ allocation system, progress has been slow, and frustrations are properly felt. But that is, in good part, for two reasons. One, because UNOS has not done the job that it should; and, two, because there is a distinct shortage of organs available to the people who have needed them.

The act was designed so that the Secretary of Health and Human Services could work through a private contractor. That is good. The organ procurement transplantation network has expertise in the field of organ allocation. This contractor is and always has been UNOS of Richmond, Virginia. I would note it has not done a very good job in the public interest. It has fought the Secretary every step of the way. Indeed, it has sought to terminate the Secretary's power to issue regulations.

It has done worse than that. It has taken steps to set itself firmly as the everlasting contractor who will handle organs allocation. UNOS has engaged in an unprecedented lobbying campaign against any changes in its allocation policies. It has also misrepresented the positions of the Secretary. It is a very deceitful institution.

Let us note the regulation which is in question. It tells UNOS to propose an improved allocation system. That is all the Secretary wants it to do. But this is anathema to UNOS, and it is something which this Congress cannot permit.

There is more bad to be said about UNOS, and there is more bad to be said about this legislation.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Missouri (Mr. BLUNT).

Mr. BLUNT. Mr. Chairman, I thank the gentleman from Virginia for yielding me this time.

Mr. Chairman, I come up in opposition to the rule; and because of that, I am for the bill. The rule is a power grab. The bill is a continuation of where this Congress has been for the past 16 years. The bill continues to safeguard this network that ensures that the States still have some responsibilities, some incentive, some reason for their State to do a better job of procuring organs than other States. If we take that out of the system, we really lose a lot of the success of this system.

Whenever one talks to people about where their organs will be used if they are given as part of their final decision

making, they are more receptive to those organs being used close to home if there is a need close to home. I would like to see a list that the gentleman has of healthy people who are getting organs when sick people are not. I think this will help this debate. I believe this is not happening in this system today.

In 1990, Senator ALBERT GORE testified before a subcommittee of the Health and Environment Committee. Senator GORE attacked HHS's bureaucratic interference with the independence of the organ procurement and transplant network.

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He testified that the career bureaucrats were interfering with the network's policymaking efforts. In fact, he charged that HHS bureaucrats teamed up in an attempt to remove all policymaking authority from the network in contradiction to the law.

Even a stopped clock is right twice a day. Senator GORE was right in 1990. We are right today if we pass this bill.

Mr. BROWN of Ohio. Mr. Chairman could you let each side know how much time we have?

The CHAIRMAN. The gentleman from Ohio (Mr. BROWN) has 16½ minutes remaining, and the gentleman from Virginia (Mr. BLILEY) has 15½ minutes remaining.

Mr. BROWN of Ohio. Mr. Chairman, I yield 4 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Chairman, I thank my colleague, our ranking member on the Subcommittee on Health and Environment, for yielding me this time, particularly since he knows we are on opposite sides on this issue.

Mr. Chairman, in Texas we have a saying, "If it ain't broke, don't fix it." Our current system is not broke. It needs to have a tune-up, but it is not broke, and the HHS rules go much too far.

I am proud to be an original cosponsor of this bill, because I believe it would move forward the debate on the crucial issue of organ transplant policy. While I strongly support the legislation, I am also concerned about our timing today. I know we are trying to work out a compromise. Our colleagues on the Senate side, Senator FRIST and Senator KENNEDY, are working on this and are meeting with organ transplant representatives to hammer out a compromise. I am hoping our actions today do not jeopardize real bipartisan solutions that are being developed. Hopefully, this bill today will move this issue forward.

There is plenty of room for compromise on both sides. We all agree that medicine and science, not politics, should oversee our Nation's organ transplant policy. Yet we are not seeing much sign of compromise from the

administration on this issue. The Department of Health and Human Services' final amended rule on organ transplantation is a farce. It does not move enough from the original proposal. Likewise, those in the organ community, who refuse to budge an inch toward compromise, are simply stalling the process in an unproductive waste of time.

The organ transplant surgeons in Houston and experts in Houston and the surrounding area have done a good job of contributing to the debate. They are willing to approach the matter in a deliberative and sensible manner. They simply want what is best for their patients and their community. Like me, I believe that the HHS regulation could leave small- and medium-sized transplant centers at a significant operating disadvantage, which will ultimately cause them to shut their doors, leaving thousands of needy patients few options except to go to the larger centers.

H.R. 2418 contains many good initiatives. It goes beyond organ allocation policies to deal with the related issues, not only how organs are allocated but the number we have to allocate. The legislation creates a new \$5 million grant program to pay for travel and other expenses for living organ donors. It authorizes \$2 million for carrying out studies and demonstration projects that will increase organ donations, and it requires the network to work actively to increase the supply of donation of organs.

Mr. Chairman, the concern I have is that we may lose the success in some States with a higher percentage of organ donations. Walking over here I had a discussion with a colleague of mine from Wisconsin who said that Wisconsin does a great job in trying to increase organ donations, yet some other States may not. So what we will see is some State doing a great job having their organ donations transferred to somewhere else that is not doing a good job.

That is why this bill is needed and why it is so important, Mr. Chairman. I regret that HHS has chosen to force the new regulations on the transplant community that nearly unanimously rejected them. If we continue to stalemate, no one will benefit. That is why we need to move forward with this legislation and hopefully come up with a compromise.

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee (Mr. BRYANT), a member of the committee.

Mr. BRYANT. Mr. Chairman, Congress should pass this legislation today because it reauthorizes the National Organ Transplant Act of 1984. Back then, Congress in its wisdom set up a private partnership between the medical community and patients. Congress decided that the difficult decisions, the medical decisions involving the alloca-

tion of scarce organs should be made by this private partnership and not by government officials. That is the way the system has worked very well for 15 years.

This legislation does give the Secretary of HHS some oversight authority, and that is how it should be. But this bill leaves the real medical decision making about who gets organs firmly within the transplant community, which is exactly where it belongs.

I urge my colleagues to strongly support H.R. 2418, as it is the right bill at the right time.

Mr. BROWN of Ohio. Mr. Chairman, I yield such time as he may consume to the gentleman from Texas (Mr. BENTSEN).

Mr. BENTSEN. Mr. Chairman, I rise in support of H.R. 2418, the "Organ Procurement and Transplantation Network Amendments," a measure that I am cosponsoring.

This legislation, H.R. 2418, would reauthorize the National Organ Transplantation Act, which was enacted to provide for the establishment and operation of an Organ Procurement and Transplantation Network. This Network would be responsible for developing, establishing and maintaining medical criteria and standards for organ procurement and transplantation. This bill would also promote efforts to increase the supply of organs available for transplantations.

Every year, more than 20,000 people receive organ transplants in the United States. While we have made great strides in providing these life-saving procedures, only one in three candidates for organ transplants actually undergo surgery. In the last decade alone, the waiting lists for transplants have grown by over 300 percent. The key to solving the organ allocation crisis is to increase the supply of donor organs. H.R. 2418 encourages organ donation through new, innovative programs aimed at increasing the number of living donors and recognizing organ donors and their family members.

This legislation, H.R. 2418, would require the Secretary of Health and Human Services (HHS) to create a program to educate the public with respect to organ donations. This bill would also authorize a new grant program to cover the costs of travel and subsistence expenses for individuals who make living donations of their organs. In addition, H.R. 2418 acknowledges the advances in medical technology that have enabled transplantation of organs donated by living individuals to become a viable treatment option for an increasing number of patients.

This bill also provides some much needed clarification to the relationship between HHS and the Organ Procurement and Transplantation Network (OPTN) to reflect what Congress intended when it first established the network in 1984. Congress has consistently recognized that the management and formulation of organ donation and transplantation policies are best left in the hands of those who are directly affected—the medical community, patients and donors. The original 1984 legislation provided for a network that is a private sector entity receiving HHS assistance relative to contract funding. The 1984 law did not au-

thorize HHS to establish medical criteria or policies for the network. This measure insures that organ allocation policies are decided locally.

Therefore, Mr. Chairman, I urge the Congress to pass this valuable legislation which not only promotes organ donation but also assures that those with medical expertise can work with patients, donors and their family members to develop the best organ policy.

Mr. BROWN of Ohio. Mr. Chairman, I yield 3/4 minutes to the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Chairman, let me give some background on this issue. In the mid-1980s, we did not have any Federal involvement in this area, and we found that there was an ad hoc region-to-region system in place to procure organs and to distribute them. So we adopted a law to set up a national organ recruitment and distribution system so that anyone in this country would have a fair chance to get an organ when they needed that transplantation. The biggest problem we have in this country is we do not have enough organs for all the people that are waiting.

Now, this national law was created to establish a national system, and whenever an individual lived they would not be penalized because they lived in a particular location. We wanted this distribution system; and to work it all out, the government contracted with an organization called UNOS. UNOS is a private organization. They have a government contract to set up this system. Now, UNOS is a private organization, but they are supposed to be working on behalf of the public.

The Secretary proposed some changes on the allocation system to make it more equitable nationally. UNOS did not like that, and they spent a lot of their money lobbying against it. They argued that what is happening is there is a top-down system being put into place, and they stirred a lot of commotion against the administration's original proposal.

Well, after that proposal was offered, the Institute of Medicine did a study. They evaluated the situation and they came up with some good recommendations, which are part of the LaHood amendment, which I will be supporting later. The bill before us is not to incorporate the constructive proposals, but it is to say the original proposal of the Secretary was not good, the subsequent proposal we are not even going to look at, and we are going to turn the whole system over to UNOS, and UNOS will run it and UNOS will not have to be accountable to anybody.

They will, in effect, be the ones to take the place for the protection of the public interest. But there will be no public accountability on behalf of UNOS. UNOS would have veto power over every single aspect of our Nation's organ allocation system, everything from who gets an organ, who does not,

to how it spends the fees patients have to pay UNOS to get an organ. UNOS could spend all its fees on expensive trips lobbying Congress or a new \$7 million headquarters that they are actually talking about spending money on, and the American public would be powerless to stop them.

I think this bill is fatally flawed. We should never contract with a group and then turn over to them all this power. I think it is probably unconstitutional, but it is certainly a bad idea. Let us make sure that UNOS works for us and we do not just work for UNOS. What we want is a fair, equitable system.

Ironically, UNOS, on March 15, 2000, wrote to the gentleman from Michigan (Mr. DINGELL) saying UNOS and HHS are working closely together to ensure an effective and efficient implementation of these rules, including an organ allocation provision. Why should we step in now and say we are not going to let the Secretary be involved, we will just let UNOS decide this policy on their own?

I urge opposition to the bill.

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentleman from Wisconsin (Mr. GREEN).

Mr. GREEN of Wisconsin. Mr. Chairman, I thank the chairman for yielding me this time.

As I suspected, today there is a lot of testimony aimed primarily at muddying the water. Let me boil this bill down, this good bill, to two simple facts.

Fact number one: Back in 1984, Congress tried to take politics out of this process and turned decision making over to health care professionals. That is this entity we keep hearing about, UNOS, as though it is some alien creature.

UNOS is comprised of health care professionals in this field. Now, unfortunately, the bureaucracy is striking back and wants to repoliticize the process.

Fact number two: There is a tremendous shortage of organs nationwide. But some States, like my home State of Wisconsin, are doing a great job through public education and have a high percentage of organ donations. Unfortunately, the bureaucracy wants to punish States like Wisconsin, which is doing a good job, and wants to put them down and send the organs elsewhere. Only in Washington would this make sense to some people.

Fact number one: Let us keep politics out of this process. Fact number two: Let us reward States that are doing a good job. Please support this bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Chairman, I thank the gentleman for yielding me this time.

As a physician, I rise to register my strong opposition to H.R. 2418 and in support of the revised regulations that were established by the Department of Health and Human Services which seek to address the inequities that exist in the current transportation policies. That is why I support the Moakley-LaHood-Peterson-Rush amendment.

The only determining factors that should be taken into account when deciding who gets a transplant and when is availability of the needed organ and medical necessity. We cannot allow that determination to be based on where one lives. That would not have helped my constituent, Vincent George, or the many others who are alive today because they were lucky enough to get an organ when it was medically necessary.

Mr. Chairman, people of color right now do not have equal access to organ transplantation. While I commend the sponsors of this bill for creating new incentives to encourage people to become organ donors, I cannot believe, as the supporters of this bill would have us to, that a person willing to be a donor would not want that organ to go to the person who needs it most.

This bill is seriously flawed because it ignores the recommendation of the independent study authorized by this body that there be Federal oversight of the OPTN, and also because it does not require standardization of patient listing practices and broader sharing of organs, which is essential to ensuring fairness in the system and optimal outcome for patients.

We cannot run the risk of allowing profit motives or politics to impact in any way in the organ allocation process. We must act to promote and protect the public health. I ask that the bill H.R. 2418 be opposed and that my colleagues support the access of all of the people of this country to a transplant whenever it becomes medically necessary no matter where they live. The Department must have oversight. I support the LaHood-Moakley-Rush-Peterson amendment.

Mr. BLILEY. Mr. Chairman, I yield myself 1 minute, because I am confused.

Some of my colleagues on the other side of the aisle, my ranking member, the gentleman from Michigan (Mr. DINGELL), and my good friend, the gentleman from California (Mr. WAXMAN), are saying that we should let the Secretary make these decisions as to where these things should go. Well, just a few months ago they were here on the floor arguing overwhelmingly for the Dingell-Norwood bill saying just the opposite; that when we have medical decisions they should be made by medical people, not by bureaucrats.

□ 1230

It is somewhat confusing. I also heard that healthy people are getting

organs before the sick but that, yet, nobody can come forward with any names. We had the great baseball player Mickey Mantle mentioned. He had cirrhosis of the liver. He was a category three. As he got sicker and sicker, he moved up to category two, finally up to category one when he got his liver. He did not go to the head of the line.

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

Mr. BROWN of Ohio. Mr. Chairman, how much time does each side have remaining?

The CHAIRMAN. The gentleman from Virginia (Mr. BLILEY) has 12½ minutes remaining, and the gentleman from Ohio (Mr. BROWN) has 7¼ minutes remaining.

Mr. BROWN of Ohio. Mr. Chairman, I reserve the balance of my time.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Alabama (Mr. BACHUS).

Mr. BACHUS. Mr. Chairman, I love this body because we start off talking about all sorts of esoteric comments and then, as the debate narrows, we really get to what the issue is.

As the gentlewoman from the Virgin Islands (Ms. CHRISTENSEN) says, I support HHS; I support Donna Shalala. I believe that she ought to set policy and procedure for organ transplants.

Those of us who support H.R. 2418 think it ought to be where it has been for the last 16 years, with the medical community, with the transplant community, with the donors, with their families, with the professionals.

That is all this vote is about: Do we give oversight to the Federal Government, do we involve the bureaucracy, or do we allow the medical community to make medical decisions?

There are problems with the system. There is a shortage of organs. H.R. 2418 addresses that. But we have no shortage of Federal bureaucracy in the system. Let us keep it out. Let us keep it the best system in the world where it is today. Let us keep the government, let us not make it a Federal Government system. Let us keep it in the organ transplant community where the vast majority of medical professionals and patients and their families and volunteers say it ought to be.

Mr. Chairman, I support H.R. 2418 because I believe organ transplant science and organ transplant policy in the United States is the very best in the world. The bill before us today is designed to build on the achievements made since passage of the original National Organ Transplant Act in 1984, legislation that set up the current system for organ transplant policy in the United States.

You will hear today from others who will argue that they have a better plan. One that would give the Federal Government more control over transplantation. Unfortunately, their proposals would wrest authority from the very people, the organ transplant community, who are responsible for the modern system of

organ transplantation that has saved thousands of lives.

The transplant community, not the Federal Government, was given this responsibility, under the 1984 NOTA law, because Congress believed that those who are on the front lines know what the best transplant policy should be, and because new developments and breakthroughs in medical science could quickly be implemented into the system. That is why we have the best transplant system in the world and that is why we need to continue to develop transplant policy in the private sector transplant community.

What we should do today is support H.R. 2418 because it is the one bill that recognizes the contributions made by the thousands of patients and their families, volunteers, and medical professionals that make up the transplant community. It keeps transplant policy decision-making in the private sector and it focuses on the real problem in transplant policy, the shortage of organs.

Since 1984, the number of people receiving organs has increased each year. In 1998, more than 21,000 Americans received the "Gift of Life." Unfortunately, donation rates are not keeping up with the demand for transplants and it is imperative that we in Congress do everything we can to encourage more organ donation. That is what H.R. 2418 seeks to do. I urge my colleagues to support this bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Chairman, there is a great misapprehension about what is going on here. The only thing that the Department of HHS has suggested to the UNOS people is that they should come forward with new allocation policies which are fair.

Now, why is that necessary? First of all, it is necessary to consider the fact that some patients are sick and are going to die if they do not get an organ transplant. There is also the need to consider the disparity that exists between minority groups and Caucasians. Unfortunately, minority groups are not infrequently waiting longer than are Caucasians.

It is also true that, under the allocation system now in place by UNOS, we are finding there are major differences between different parts of the country. For example, in two major liver transplant centers in Kentucky, one transplant center has waiting times of 38 days and the other 226 days. That needs to be addressed. In Louisiana, in one center it is 38 days. In another it is 226. In Michigan, the difference is 161 days and 401 days.

Imagine if one lives in the State where the wait is longer and imagine then what their vote would be on this particular piece of legislation. Because, in those areas, sick people are dying because they are not being fairly treated. That is what is at stake.

HHS has called on UNOS to come forward with a newer, fairer, better allocation system. And that is what UNOS is rejecting, and that is why we are op-

posing this particular legislation. We think that this should be done in a fair fashion and done under the direction of the Secretary, not under the direction of a self-serving contractor.

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentleman from Oregon (Mr. WALDEN).

Mr. WALDEN of Oregon. Mr. Chairman, I rise today in support of this legislation. I do so both from a personal standpoint and from a public-policy standpoint.

When I served in the Oregon legislature, I worked hard to reform our anatomical donation process so that everybody on their Oregon driver's license can list this on the back; so, indeed, if they are killed, they are immediately available if they want to have their organs transplanted.

I stand here today as a father whose son died waiting for a heart transplant. He never received that transplant but was in line to. He died before we had the opportunity to get him to where he could get that.

I want medical professionals making this decision, not the agency that brings us HCFA and regulations and bureaucracy. I want an effort that causes other people to sign up to be donors and to be active in this process to give the gift of life. That is best done through this legislation, Mr. Chairman.

Mr. BROWN of Ohio. Mr. Chairman, I reserve the balance of my time.

Mr. BLILEY. Mr. Chairman, how much time do I have remaining?

The CHAIRMAN. The gentleman from Virginia (Mr. BLILEY) has 9½ minutes remaining, and the gentleman from Ohio (Mr. BROWN) has 6¼ minutes remaining.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Oklahoma (Mr. ISTOOK).

Mr. ISTOOK. Mr. Chairman, I support this bill. This bill will stop a power grab by the administration, one of the most distasteful power grabs that we have seen.

The administration says the Federal Government should decide and control what happens to their body when they die. If they want to donate an organ, then Uncle Sam's bureaucrats will take over to decide what is going to become of their heart, their kidneys, their liver; and they will decide who can get a transplant and who cannot.

It is tough enough for doctors and hospitals to have to make that decision on medical judgment. We do not need bureaucrats making it instead. So this most personal decision would become a Federal issue. States right now go to great lengths to encourage people to be organ donors.

Some, like Oklahoma, are very successful in this effort with driver's licenses and other ways of indicating their desire. Other States, well, they do not have as much success so they want the administration to help them, to

help them reach over to where there are people willing to make organ donations and reach over and grab those and take them to where they want them, all through a Federal power grab, not by encouraging more people to donate but by saying, we are going to reach in and take from where people have a successful program underway.

Now, if their State wants a different system, then their State ought to have the ability to do so. Who says the Federal Government is in charge of everybody when we die? Who? Not me. Not the Constitution.

Do not let this power grab happen. Unless we pass the bill, Federal bureaucrats will become the masters of what happens to our bodies when we die: our lungs, our heart, our kidney, our liver, whatever it may be. It has to be approved by the Federal Government before we can be an organ donor. Stop the power grab. Do not cut off the incentive for the States. Support this bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1 minute to my friend, the gentleman from Pennsylvania (Mr. MASCARA).

Mr. MASCARA. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, I rise today to express my opposition to H.R. 2418, the Organ Procurement and Transplant Network Amendments of 1999.

This misguided approach to addressing our Nation's organ-sharing needs goes against logic. The current system is not working, and the bill preserves the status quo. An estimated 68,000 Americans are on the waiting list for an organ transplant. A new person is added to the list every 16 minutes, and each day 10 to 12 people die while still waiting for a transplant.

Last year, Congress asked the Institute of Medicine to examine the current organ-sharing system. The IOM report clearly supported restructuring the current system to be more responsive to the needs of the public. The bill does nothing to accomplish that.

I ask my colleagues to support the LaHood-Moakley substitute amendment and oppose H.R. 2618. Let us fix the organ-sharing system to help our Nation's sick, not hurt them.

Mr. BLILEY. Mr. Chairman, I yield 3 minutes to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Chairman, I thank the gentleman for yielding me the time, even though we may disagree on this policy.

Mr. Chairman, I rise to state that this bill needs further work. We have an amendment a little later that will do that.

I want to share with my colleagues from the Forbes report. Last year 485,000 Americans died while waiting for transplants. This does not even count people pulled off the list after they became too sick to handle a transplant.

It is a matter of debate how much lower the number of deaths would be if the system for obtaining and allocating organs were more rational, said the Forbes record, more rational.

The next one they stated, most doctors involved in the business fear offending UNOS lest their organ supply be affected. We have a system that has our physicians afraid to speak up for fear they will not get organs. We have heard today that it should be a totally independent network. And I say, responsible to whom? Show me anything that should not be responsible to somebody.

We also heard today that the sickest candidates first would cost lives. I am waiting for that evidence. I am waiting, because I believe that is a mistake, anybody who made that statement.

It says the decision should be in the hands of doctors and not in the hands of bureaucrats. Share with me, also, how urging the system to have a fair allocation system puts anything in the hands of bureaucrats. We are asking them do it a little better. We should.

I also heard today that all transplant centers in all States are all equally successful. Well, I want to share with my colleagues today, if they are going to have an organ transplant, look at how often they do it. Look at their success rate. My colleagues, they vary.

Each of us hope we never need an organ transplant. But we sure hope that economics should not rule over good medical decisions.

The amendments we are going to get will take what this bill bypassed, the report that was given to us by the Institute of Medicine. Allocation policies should be based on sound medical principles and valid scientific data. Allocations should be designed to share organs over as broad a geographical area as possible. It did not say how. It did not say how far. It said as far as possible.

I live 50 miles from a State border. I would hate to think because I live 50 miles outside of the State next to me I might not get an organ or somebody in that State might not get an organ because they were 50 miles outside of that State.

My colleagues, we need medical principles driving the system. There are huge flaws in the system. The legislation that is before us gives almost no oversight to anybody to the system.

We do not want bureaucrats; nobody wants bureaucrats making decisions. And bureaucrats will not make decisions. We, as a Congress, cannot let them make decisions. But we need economics not to drive this system. We need good medicine to drive this system. And if they do, we will amend this bill later and improve it.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I would like to first reiterate as we close this debate the

opposition to this bill from the administration and the belief from the Department of Justice that this bill is unconstitutional.

The Statement of Administration Policy says, "The Administration strongly opposes House passage of H.R. 2418. It raises serious constitutional issues, would preserve existing inequities in the organ transplantation system, and could result in potential harm to patients. If H.R. 2418 were presented to the President in its current form" it says in this Statement of Administration Policy, "his senior advisors would recommend that he veto the bill."

In a letter from the Justice Department to the Speaker of the House, the Assistant Attorney General writes, "We believe that to the extent Congress intends to insulate the Network's exercise of policy-making authority from the Secretary's supervision, the proposed legislation raises significant constitutional concerns. Nevertheless, even if the courts were to sustain the legislation in the face of a constitutional challenge, we would strongly oppose the bill's restrictions. As the bill seeks to remove from the executive branch important oversight functions, it appears to constitute a substantial and unnecessary intrusion into the executive branch's role of implementing Federal regulatory programs and to compromise the core governmental value of political accountability for policy decisions affecting the public."

Mr. Chairman, I am pleased to hear my Republican colleagues talk over and over about how we should leave it to the medical profession to make medical decisions. We on this side wholeheartedly agree and are glad to see our colleagues finally coming around.

For the past 3 years, we have been concerned that HMO bureaucrats are making medical decisions, not doctors, and have been working with the gentleman from Georgia (Mr. NORWOOD) to change that.

We have a piece of legislation, the Patients' Bill of Rights, which would fix this problem and allow physicians with their patients to make these decisions. This bill is now in conference. My colleagues' words today give many of us on this side encouragement that we can actually achieve success in the conference committee on the Patients' Bill of Rights in this very important issue.

Mr. Chairman, this legislation in front of us today is fundamentally flawed. It turns our organ allocation system from representatives of the public, our elected and appointed officials, who are charged with representing the public and advocating and protecting the public interest, it turns those decisions over to a private bureaucratic organization which, in the end, has no real accountability to taxpayers.

Mr. Chairman, I urge my colleagues to follow the recommendations from

the Institute of Medicine. I urge my colleagues to vote "yes" on the LaHood amendment, and I urge my colleagues to vote "no" on the underlying legislation.

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

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, in closing, I would like to make three points why we should adopt this legislation. First of all, one of the speakers just recently in the well says there is nothing here to stop these people from making decisions, we just want them to make better decisions.

Well, who is to determine whether they make better decisions? Bureaucrats at HHS, not medical people, not doctors. They are the ones that would be making the decisions.

Congress, when we passed this originally, said, we want these decisions which most often determine life and death to be made by medical people devoid of politics. And that is why the overwhelming reason why we should adopt this bill.

We then heard about the Justice Department and questioning the Constitution. Well, does the sick chicken case still rule the roost?

The Department of Justice questions whether delegating public policy to a private entity violates the Constitution and whether *Schechter Poultry Corporation v. United States* (295 U.S. 495 (1935)) still serves as a barricade.

In 65 years, the court has not struck down as unconstitutional any such delegation. And, indeed, the late Justice Thurgood Marshall once wrote, "The notion that the Constitution narrowly confines the power of Congress to delegate authority to administrative agencies, which was briefly in vogue in the 1930s, has been virtually abandoned by the Court for all practical purposes."

□ 1245

These are red herrings, Mr. Chairman. This is a good bill. The gentleman from Oklahoma (Mr. ISTOOK) put it right. What this is is a power grab on the part of the administration to reward a couple of institutions to the detriment of the States. We should enact this resolution, and we should oppose the LaHood amendment.

Mr. SPENCE. Mr. Chairman, I am pleased that the House will today consider H.R. 2418, the "Organ Procurement and Transplantation Network Amendments." I am proud to be a cosponsor of this important measure, and I rise in unequivocal support.

My friends at the United Network for Organ Sharing (UNOS) tell me that I am probably the longest living double lung transplant recipient in the world. My successful surgery, like the successful surgery that has been performed on other recipients more than 200,000 times since the early 1980's, was made possible by the hard work and dedication of this nation's

transplant community. I am alive today because of the countless doctors, nurses, transplant coordinators, and other dedicated individuals who worked tirelessly for my survival. This is, indeed, a remarkable group of people.

These are the same people to whom Congress gave the enormous responsibility of operating the Organ Procurement and Transplant Network (OPTN) when organized in 1985. They have responded with the enthusiasm and dedication we expected, freely contributing more than 1.5 million man-hours to the effort. The result of their collective labors is a transplant system that is the envy of the world. It is fair, objective, and it is in the proper hands—the doctors, patients, donor families, and other experts who care most.

We suffer from a tragic shortage of organs. I commend Secretary Shalala for her attention to the important issue of organ donation. However, I fear that the plan promulgated by the Department of Health and Human Services (HHS) would not have the intended effect. Instead, the HHS plan would remove an integral element of the organ donor network—the intimate and private relationship between transplant professionals, patients, and donor families. The focus must be placed on increasing organ donation and organ donor awareness nationwide. H.R. 2418 addresses this problem by directing the Secretary to carry out a program to educate the public with respect to organ donation, with particular emphasis on the need for additional organs for transplant. I am also pleased to learn that this measure would authorize grants to cover the costs of travel and subsistence expenses for individuals who make living donations of their organs.

Mr. Chairman, it is vitally important that Congress reauthorize the NOTA. We must also ensure that the decision making process remain in the hands of the experts directly involved in the transplant community. I urge my colleagues to join me in supporting the "Organ Procurement and Transplantation Network Amendments."

Mr. POMEROY. Mr. Chairman, I rise in opposition to H.R. 2418, the Organ Procurement and Transplantation Network Act. I strongly support efforts to increase the number of organ donors and the supply of organs available for transplantation. I also believe that medical decisions should be made with input from the medical community. In trying to address these issues, however, H.R. 2418 brings up questions of constitutionality, competition, and financial abuse.

This measure would give the United Network for Organ Sharing (UNOS), the current Organ Procurement Transportation Network (OPTN) contractor, broad regulatory authority. It takes away all meaningful oversight from the Department of Health and Human Services, placing functions of a "scientific, clinical, or medical nature" within the sole authority of the OPTN. According to the Department of Justice, this raises "significant constitutional concerns." A private entity cannot be granted regulatory authority without executive involvement.

H.R. 2418 also raises serious concerns regarding competitive practices. This measure would require that any new contractor selected by the Department of Health and Human Serv-

ices to run the OPTN must receive the written endorsement of a majority of the network's contractors. This requirement protects UNOS, the long-standing contractor, from competition and violates the Federal Acquisition Regulation which mandates competition in all government contracts.

Our country has had a long-standing ban on the sale of organs, a ban that could be compromised if H.R. 2418 were to become law. The measure allows the OPTN to accept "gifts of money or services" from patients on transplant waiting lists, but fails to state that preferential treatment may not be given to these patients on the basis of their gifts. In effect, these patients could "buy" their way up the list and into a transplant for the right price.

Finally, I am concerned by a current trend among states to pass laws that give priority in organ transplantation to state residents over out-of-states residents, regardless of medical necessity. While we must continue to encourage organ donation nationwide, our intent must be to serve those with the greatest needs.

Mr. STARK. Mr. Chairman, I rise in opposition to H.R. 2418, the Organ Procurement and Transplantation Network Amendments of 1999 and in support of the amendment offered by Representatives LAHOOD, MOAKLEY, RUSH and JOHN PETERSON.

Without this bipartisan amendment, H.R. 2418 will result in needless deaths and is bad health policy.

More than 66,000 Americans currently await an organ. Every day about 13 people die waiting for a transplant. If we want to save lives, or nation's organ allocation system must be improved—unfortunately, H.R. 2418 is not the answer.

Organ allocation policies established by the United Network for Organ Sharing (UNOS), the current private contractor in charge of distributing organs procured for transplant, are inequitable. Under UNOS' system, patients with similar severities of illness are treated differently depending on their location. UNOS' system relies more on geography than medical urgency; consequently, organs are offered first to people in a local, regional area and only when there are no local patients available is the organ offered to sicker patients on a broader level. This means that some of the most deserving patients will not receive an organ solely because of where they live or where they seek treatment—which often times is a managed care plan's decision. H.R. 2418 would preserve these existing inequities.

In addition to permitting such inequities, H.R. 2418 has many other flaws. The President's senior advisors will recommend that he veto the bill in its current form. H.R. 2418 would strip public accountability over the nation's organ allocation system and give power to a private contractor—a delegation of federal authority that the Department of Justice cited as raising "constitutional concerns." This bill would also provide the current, private contractor (UNOS) with a monopoly over the organ procurement contract, and contradict the recommendations recently set forth by the Institute of Medicine.

Further, H.R. 2418 protects centers from releasing comparative transplant center information to the general public and eliminates the

scientific registry that currently provides this data. Last fall, the Department of Health and Human Services (HHS) publicized transplant center performance data. This comparative information includes all patients who came onto the transplant waiting list between April 1994 through the end of 1997. Although this data was adjusted to correct for differences in the severity of patient illness, the data still revealed a wide disparity in transplant center outcomes nationwide.

For example, the data show that under the current organ contractor's policies, a patient's chance of receiving an organ transplant depends on geography, not on medical need. For example, in some areas of California, patients had a 71% chance of receiving a liver transplant within one year, whereas patients had only a 24% of receiving a liver transplant in other areas of California.

In December 1999, the New England Journal of Medicine concluded that liver-transplantation centers in the U.S. that perform 20 or fewer transplantations per year have significantly higher mortality rates than those centers that perform more than 20 transplantations per year. If enacted, H.R. 2418 would make it difficult for patients to access such life-saving information about transplant centers.

In addition, H.R. 2418 contradicts the Congressionally-mandated National Academy of Science's Institute of Medicine (IOM) report. In 1998, Congress delayed Health and Human Service (HHS) regulations intended to improve organ allocation and transplantation nationwide and called upon the IOM to study the current system. The IOM's July 1999 report overwhelmingly supports the HHS regulations and directly contradicts H.R. 2418 provisions. For example, the IOM called for increased federal (HHS) oversight over the organ allocation system. In contrast, H.R. 2418 constitutes an unprecedented attempt to give a federal contractor control over life-and-death health care policy decisions as well as control of more than billions in taxpayer dollars—with no meaningful oversight by the government.

The HHS organ allocation regulation attempts to move to a system based on medical necessity instead of geography, with medical professionals making medical decisions about the best way to allocate the limited number of donated organs. The newly revised rule incorporates comments and recommendations from the IOM, UNOS, transplant and advocacy communities, patients, and the general public to ensure the neediest patients receive organs first—regardless of where they live. Further efforts to delay this rule will only cause needless deaths.

H.R. 2418 ignores the impartial view of the IOM scientists whereas the HHS regulation incorporates the impartial recommendations of the scientific community. In fact, a January 14, 2000 issue of Science magazine reports that IOM scientists had found no evidence supporting the objections raised against the HHS final regulation. The IOM found no evidence that distributing organs across broader areas might force smaller transplant centers to close, nor that broader allocation would drive down donation rates. And the IOM found no evidence that minorities and economically disadvantaged patients would be adversely affected by broader sharing of organs.

Also, the Science article concluded that Congress has continued to struggle with the federal regulations and “the House Commerce Committee has approved a bill (H.R. 2418) which sides with opponents of the regulation and ignores the IOM recommendations for enhanced government oversight.” Members should oppose H.R. 2418 and ensure that the Administration is permitted to implement the IOM-supported HHS organ allocation regulation.

The bipartisan amendment offered by Representatives LAHOOD, MOAKLEY, RUSH and JOHN PETERSON incorporates IOM recommendations to establish a fairer national organ allocation policy. This amendment would provide public accountability through meaningful federal oversight to ensure broader sharing of organs and assure that organ allocation decisions are based on medical necessity and not accidents of geography. This amendment would also make data widely available to the public and establish a scientific advisory board that is separate from the private organ contractor. The current organ allocation and transplantation system has created great disparities in organ allocation and transplantation. This amendment would end such unfairness.

A system that offers a level playing field to all patients no matter where they live is in everyone’s best interest—medical urgency rather than geography should be the determining standard.

Oppose H.R. 2418 as well as any efforts to remove the Secretary’s legitimate oversight authority and to give a private contractor a monopoly over the nation’s organ allocation program. And support a fairer allocation system that bases transplant decisions on common medical criteria and pure professional medical opinion. The LaHood-Moakley-Rush-Peterson amendment will make these improvements a reality.

Mr. TERRY. Mr. Chairman, I rise in opposition to H.R. 2418, the Organ Procurement and Transplantation Network Amendments of 1999.

The University of Nebraska Medical Center in my District is one of the premier organ transplantation centers in the country. Gifted and dedicated doctors and surgeons at this center have performed more than 2,800 organ transplants on patients from all fifty states. They are recognized as world leaders for their exceptional success with high-risk liver transplants.

But there are simply not enough organs available to help all the terribly sick people who come to the Medical Center. And H.R. 2418 would make sure it stays that way.

Until this year, organs were allocated by geography instead of medical necessity. Transplant patients were placed on waiting lists that prioritized who gets organs first by state, then region, and lastly by nation. This geographical approach did not help the sickest patients get transplants. And it went against the intent of Congress that all Americans should be treated equitably.

The Secretary of Health and Human Services tried to increase organ sharing in 1998, but Congress delayed this plan until last year by asking for a study from the National Academy of Sciences. When this study came back,

it supported the Secretary’s efforts to allocate organs based on medical necessity. H.R. 2418 ignores this recommendation, and eliminates oversight and accountability of the organ network. This would make it even more difficult for main transplant centers like the Nebraska University Medical Center to get the organs needed to help patients. Without the Secretary’s organ sharing plan, each patient who comes to the center for help is a big fish in a very small pond of “Nebraska-only” organ donors.

Mr. Chairman, it is imperative that precious, life-saving organs be allocated by medical necessity, not geography. I oppose H.R. 2418, and strongly urge my colleagues to do the same so sick and dying patients can get the organ transplants they need to live.

Mr. DAVIS of Virginia. Mr. Chairman, I rise today in support of H.R. 2418 the Organ Procurement and Transplantation Network Amendments of 1999. I feel very strongly about the importance of supporting the transplant community in their important life-saving work and am proud to have signed a pledge to be an organ donor myself.

My own sister-in-law was blessed with a second chance in life when she was fortunate enough to receive a successful kidney transplant. The lives of more than 20,000 men, women and children are now saved each year by liver, kidney, pancreas, heart, lung, intestine, eye and tissue transplants.

On April 2, 1998, Labor Health Services Secretary Shalala issued a regulation that would result in an unprecedented federal takeover of the organ transplant system. On three separate occasions, Congress imposed a moratorium that spanned almost two years. Now that the moratorium has expired, and the final HHS rule has become effective, I am deeply concerned that the new rule will penalize patients in states, such as Virginia, which have been successful in increasing organ donation, by forcing the shipment of locally-procured organs out-of-state or even across the country. We must now act quickly to ensure that our successful organ transplant program is not harmed.

H.R. 2418 will ensure that decision-making regarding organ transplantation will remain, as originally intended under the National Organ Transplant Act, within the transplant community. The distribution of organs should be based on medical criteria established by the Network and not by the political forces that have tainted the promulgation of this new rule. It is the medical profession and transplant community that should be the authority in determining how to adjust allocations policies to account for new technology and new medical innovations.

Unfortunately, not every person in need of an organ or tissue is able to receive a life saving transplant. One American dies every three hours because of a shortage of donor organs, and nearly 50,000 Americans are on a national register awaiting organ and tissue transplants. The key to solving the organ allocation crisis is to increase the supply of donor organs. H.R. 2418 also addresses this problems by creating new incentives for people to become organ donors. Furthermore, this bill provides for studies to discover innovative and successful approaches to organ recovery and donation around the country.

I commend Chairman BLILEY, Chairman BILIRAKIS, and Representatives PALLONE and GREEN for their efforts in bringing this critical piece of legislation to the floor. And I urge my colleagues to vote in support of H.R. 2418 to ensure that life and death decisions involved in organ transplantation remain in the hands of the transplant community and the medical professionals involved in transplantation every day.

Mr. RILEY. Mr. Chairman, I rise today in support of H.R. 2418. This important legislation addresses a serious health concern—the shortage and accessibility of donor organs for transplantation.

Mr. Chairman, in my home state of Alabama, we have about 1,600 people currently awaiting an organ transplant. For many of these people, time is running out. However, instead of attempting to help them, the Department of Health and Human Services is playing unfairly with their lives.

H.R. 2418 will fix this dilemma in several ways. First, it will keep decisions about organ transplants in the hands of the local medical community, like the professionals at the University of Alabama at Birmingham, and away from Washington bureaucrats. Second, the legislation will encourage more people to donate their organs because they will be able to help those in their community first.

Mr. Chairman, it is clear that places like UAB can serve those needing organ transplants much better than HHS. I urge my colleagues to support this legislation and do our part to help them as well.

Mr. BLILEY. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the committee amendment in the nature of a substitute printed in the bill shall be considered as an original bill for the purpose of amendment under the 5-minute rule and shall be considered read.

The text of the committee amendment in the nature of a substitute is as follows:

H.R. 2418

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Organ Procurement and Transplantation Network Amendments of 1999”.

SEC. 2. FINDINGS.

(a) IN GENERAL.—The Congress finds as follows:

(1) It is in the public interest to maintain and improve a system for promoting and supporting a central network in the private sector to assist organ procurement organizations and transplant centers in the distribution of organs among transplant patients and the provision of organ transplantation services, and to assure quality and facilitate collaboration among network members and individual medical practitioners participating in network activities.

(2) The Organ Procurement and Transplantation Network (“Network”), which was established in the private sector pursuant to a contract awarded by the Federal Government, should continue to be operated by a nonprofit private entity pursuant to a contract with the Federal Government.

(3) The Federal Government should continue to provide Federal oversight of and financial assistance for the services provided by the Network.

(4) The responsibility for developing, establishing, and maintaining medical criteria and standards for organ procurement and transplantation belongs in the private sector and is a function of the Network.

(5) The Federal Government should assist the efforts of the Network to serve patient and donor families in procuring and distributing organs.

(6) The Federal Government should carry out programs to educate the public with respect to organ donation, including the need to provide for an adequate rate of such donations.

(b) SENSE OF CONGRESS REGARDING FAMILY DISCUSSIONS OF ORGAN DONATIONS.—The Congress recognizes the importance of families pledging to each other to share their lives as organ and tissue donors and acknowledges the importance of discussing organ and tissue donation as a family.

(c) SENSE OF CONGRESS REGARDING LIVING DONATIONS OF ORGANS.—The Congress—

(1) recognizes the generous contribution made by each living individual who has donated an organ to save a life; and

(2) acknowledges the advances in medical technology that have enabled organ transplantation with organs donated by living individuals to become a viable treatment option for an increasing number of patients.

SEC. 3. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK.

(a) IN GENERAL.—Section 372 of the Public Health Service Act (42 U.S.C. 274) is amended to read as follows:

“ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK

“SEC. 372. (a) IN GENERAL.—The Secretary shall by contract provide for the continuing operation of an Organ Procurement and Transplantation Network (in this section referred to as the ‘Network’), which contract shall be awarded to a nonprofit private entity that has expertise and experience in organ procurement and transplantation. The Network shall meet the following requirements:

“(1) The Network shall be an independent, nonprofit private entity that is a separate legal entity from the entity to which such contract is awarded.

“(2) The Network shall in accordance with criteria under subsection (b)(3) include as members qualified organ procurement organizations (as described in section 371(b)), transplant centers, and other entities that have a demonstrated interest in the fields of organ donation or transplantation. (Such members are in this section referred to as ‘Network participants’.)

“(3) The Network shall have a board of directors (in this section referred to as the ‘Board’). The Board shall, after consultation with Network participants, establish the policies for carrying out the functions described in this section for the Network.

“(4) The Board shall be in accordance with the following:

“(A) The Board shall include representatives of qualified organ procurement organizations, transplant centers, voluntary health associations, and the general public, including a reasonable proportion of the members of the Board who are patients awaiting a transplant or transplant recipients or individuals who have donated an organ or family members of patients, recipients or donors.

“(B) The Board shall establish membership categories and qualifications with respect to serving on the Board, and shall have exclusive authority to admit individuals to membership on

the Board. Transplant surgeons and transplant physicians shall comprise not less than 50 percent of the membership of the Board. The Board shall be limited to a total of 42 members.

“(C) The Board shall have an executive committee, and such other committees as the Board determines to be appropriate.

“(D) The chair of each such committee shall be selected so as to ensure the continuity of leadership for the Board.

“(b) GENERAL FUNCTIONS.—The following applies to the Network:

“(1) The Network shall establish and operate a national system to match organs and individuals who need organ transplants, especially individuals whose immune system makes it difficult for them to receive organs.

“(2) The national system shall maintain one or more lists of individuals who need organ transplants, shall be operated in accordance with established medical criteria, shall be operated through the use of computers, and may function on a regionalized basis.

“(3) The Network shall establish criteria for being a Network participant, shall establish medical criteria for listing patients and for allocating organs, and shall provide to members of the public an opportunity to comment with respect to such criteria.

“(4) The Network shall maintain a twenty-four-hour telephone and computer service to facilitate matching organs with individuals included in the list.

“(5) The Network shall assist organ procurement organizations in the distribution of organs. The distribution of organs shall be based on medical criteria established by the Network, and also shall be based on equity and ethics without regard to economic status of those awaiting organ transplants and without political control or influence.

“(6) The Network shall adopt and use standards of quality for the acquisition and transportation of donated organs, including standards regarding the transmission of infectious diseases.

“(7) The Network shall prepare and distribute, on a regionalized basis (and, to the extent practicable, among regions or on a national basis), samples of blood sera from individuals who are included on the list and whose immune system makes it difficult for them to receive organs, in order to facilitate matching the compatibility of such individuals with organ donors.

“(8) The Network shall coordinate, as appropriate, the transportation of organs from organ procurement organizations to transplant centers.

“(9) The Network shall work actively to increase the supply of donated organs.

“(10) The Network shall establish criteria, policies, and procedures to address the disparity in mortality rates between children and adults while waiting for organ transplants.

“(c) SCIENTIFIC REGISTRY.—

“(1) IN GENERAL.—The Network shall maintain a scientific registry of patients awaiting organ transplantation, persons from whom organs are removed for transplantation, and organ transplant recipients for the ongoing evaluation of the scientific and clinical status of organ transplantation.

“(2) REPORTS.—The Network shall prepare for inclusion in the report under section 375 an analysis of scientifically and clinically valid information derived from the scientific registry under paragraph (1).

“(d) INFORMATION AND DATA.—

“(1) IN GENERAL.—The Network shall—

“(A) provide information to physicians and other health professionals regarding organ donation and transplantation; and

“(B) collect, analyze, and annually publish data concerning organ donation and transplantation.

“(2) INFORMATION FOR PATIENTS AND GENERAL PUBLIC.—The Network shall make available to patients in need of organ transplants information in accordance with the following:

“(A) The information shall be transplant-related information specific to transplant centers that are Network participants, which information has been determined by the Network to be scientifically and clinically valid.

“(B) The information shall be designed to assist patients and referring physicians in choosing a transplant center, including information on the supply of and demand for organs.

“(C) With respect to the patient involved, the information shall (taking into account patients in similar medical circumstances) include the following as applied to specific transplant centers:

“(i) The probability of receiving an organ transplant.

“(ii) The length of time that similarly situated patients have waited historically to receive a transplant.

“(iii) Medical outcomes for similarly situated patients, which information shall be adjusted to reflect the medical risk factors for such patients.

“(D) With respect to the patient involved, the information shall include the information described in subparagraph (C) as applied to the service areas of specific qualified organ procurement organizations (other than such areas in which there is only one transplant center).

“(E) Information under this paragraph shall be updated not less frequently than once a year.

“(3) ANNUAL PUBLIC REPORT.—The Network shall annually make available to the public a report on the overall status of organ procurement and transplantation.

“(4) CONFIDENTIALITY.—Except for the release of information that is authorized under paragraph (2) or (3) by the Network, neither the Network nor the Secretary has authority to release the following information (unless authorized in writing by the patient or other entity with which the data is concerned):

“(A) Information that permits direct or indirect identification of any patient who is waiting for a transplant, or who is an organ transplant patient or recipient of an organ.

“(B) Information that permits direct or indirect identification of any potential or actual organ donors.

“(C) Information that permits direct or indirect identification of participants in Network deliberations or determinations related to practitioner or institutional qualifications, due process proceedings or peer review activities, except for information announcing final decisions of the Network.

This paragraph may not be construed as prohibiting the disclosure of information within the Network, including information disclosed in the course of interactive organ sharing operations within the Network.

“(e) STUDIES.—

“(1) IN GENERAL.—The Network shall carry out studies and demonstration projects for the purpose of improving procedures for organ procurement and allocation, including but not limited to projects to examine and attempt to increase transplantation among populations with special needs or limited access to transplantation, and among children.

“(2) CERTAIN TECHNOLOGIES.—The Network may study the impact of possible transplantation of animal organs (xenotransplantation) and other technologies to determine the impact upon, and prevent negative effects on, the fair and effective use of human allograft organs.

“(f) QUALITY ASSURANCE; MONITORING OF NETWORK PARTICIPANTS.—The Network shall monitor the operations of Network participants to the extent appropriate for determining whether the participants are maintaining compliance

with criteria under subsection (b)(3). In monitoring a Network participant under the preceding sentence, the Network shall inform the participant of any findings indicating non-compliance by the participant.

“(g) QUALITY ASSURANCE; PEER REVIEW PROCEEDINGS.—

“(1) IN GENERAL.—The Network shall develop a peer review system for assuring that members of the Network comply with criteria under subsection (b)(3).

“(2) NONCOMPLIANCE.—

“(A) PAYMENT OF DAMAGES.—The Network shall require that, as a condition of being a Network participant, each such participant agree that the Network may, through a peer review proceeding under paragraph (1), require the participant to pay damages for the failure of the participant to comply with criteria under subsection (b)(3). The Network shall establish procedures to ensure that such proceedings are conducted in an impartial manner, with adequate opportunity for the Network participant involved to receive a hearing. The Network shall identify various types of violations of such criteria and specify the maximum amount of damages that the Network may under this subparagraph require a Network participant to pay for the type of violation involved.

“(B) RESTRICTING ACCESS TO ALLOCATION SYSTEM.—If under subparagraph (A) it has been determined that a Network participant has engaged in substantial violations of criteria under subsection (b)(3), the Network may restrict the extent to which such participant is permitted to receive allocations of organs through the Network.

“(C) STATUS OF NETWORK PARTICIPANTS WITH RESPECT TO VIOLATIONS.—Subject to paragraph (3), the Network may take actions to make the public aware of the extent to which a Network participant has been required to pay damages under subparagraph (A) or has been the subject of restrictions under subparagraph (B).

“(3) CONFIDENTIALITY.—With respect to a peer review proceeding under paragraph (1), neither the Network nor the Secretary has authority to release data or information to the public relating to the proceedings without the written permission of all the parties involved, except that if damages under paragraph (2) are required to be paid, the requirement may be publicly announced after the conclusion of the proceeding.

“(h) ADMINISTRATIVE PROVISIONS.—

“(1) LIMITATION ON AMOUNT OF CONTRACT.—The amount provided under a contract under subsection (a) in any fiscal year may not exceed \$6,000,000 for the operation of the Network, including the scientific registry under subsection (c). Such limitation does not apply to amounts provided under the contract for increasing organ donation and procurement.

“(2) RELATIONSHIP BETWEEN SECRETARY AND NETWORK.—The administrative and procedural functions described in this section for the Network shall be carried out in accordance with the mutual agreement of the Secretary and the Network. For purposes of the preceding sentence, functions that are scientific, clinical, or medical in nature are not administrative or procedural functions and are within the sole discretion of the Network. With respect to the programs under titles XVIII and XIX of the Social Security Act, this section may not be construed as having any legal effect on such programs, except to the extent that section 1138 of such Act, or any other provision of such Act, provides otherwise.

“(3) NONFEDERAL ASSETS OF NETWORK.—

“(A) IN GENERAL.—No assets in the possession of the Network or revenues collected by the Network, other than amounts appropriated under section 378, shall be considered or be treated as Federal property, Federal revenues, or program

funds pursuant to a Federal contract, nor shall such assets, revenues, or nonappropriated funds be subject to restriction or control by the Secretary, nor shall any member of the Network be required by the Secretary to pay any fees to the Network, nor shall the Secretary be authorized to collect or authorize collection of service fees with respect to the Network or the scientific registry under subsection (c).

“(B) GIFTS.—This section does not prohibit the Network from accepting gifts of money or services, including gifts to carry out activities to provide for an increase in the rate of organ donation.

“(4) COMMUNITY ENDORSEMENT OF CONTRACT RECIPIENT.—In the case of any contract under subsection (a) that is awarded after the date of the enactment of the Organ Procurement and Transplantation Network Amendments of 1999, the Secretary shall select an applicant to receive the contract from among applicants that have the written endorsement of a majority of the combined total number of transplant centers and qualified organ procurement organizations that are Network participants (without regard to whether such centers or organizations endorse more than one applicant for the contract).

“(5) CHANGE IN CONTRACT RECIPIENT.—With respect to the expiration of the period during which a contract under subsection (a) is in effect, if the Secretary makes a determination to award the contract to a different entity than the entity to which the previous contract under such subsection was awarded, the Secretary shall publish in the Federal Register a notice that such change in the administration of the Network will take place, and the change may not take effect any sooner than the expiration of the six-month period beginning on the date on which the notice is so published. Such a change does not affect the membership status of any Network participant, or the membership status of any individual who serves on the Board (other than any membership position that is predicated solely on being a representative of the current contractor under subsection (a)).

“(i) ADDITIONAL PROCEDURES REGARDING OVERSIGHT AND PUBLIC ACCOUNTABILITY.—For purposes of providing oversight of and public accountability for the operation of the Network, the Secretary shall establish procedures for—

“(1) conducting public hearings and receiving from interested persons comments regarding criteria of the Network and critical comments relating to the manner in which the Network is carrying out its duties under this section;

“(2) providing such comments to the Network and receiving responses from the Network; and

“(3) the consideration by the Secretary of such comments.

“(j) EVALUATIONS BY GENERAL ACCOUNTING OFFICE.—

“(1) IN GENERAL.—The Comptroller General of the United States shall periodically conduct evaluations of the Network, including the structure and function of the Network and the relationship between the Secretary and the nonprofit private entity that under subsection (a) operates the Network. The first such evaluation shall be completed not later than one year after the date of the enactment of the Organ Procurement and Transplantation Network Amendments of 1999, and such an evaluation shall be completed not later than every second year thereafter.

“(2) INPUT FROM FIELD.—In conducting evaluations under paragraph (1), the Comptroller General shall consult with organizations that represent transplant surgeons, transplant physicians, transplant centers, and qualified organ procurement organizations, and with other experts in the field of organ transplantation, including experts who are not members of the Board of the Network or of the executive structure of the contractor under subsection (a).

“(3) PROCEDURES OF NETWORK.—The Network shall establish procedures for coordinating with the Comptroller General for purposes of evaluations under paragraph (1).

“(4) REPORTS TO CONGRESS.—

“(A) COMPTROLLER GENERAL.—The Comptroller General shall prepare reports describing the findings of evaluations under paragraph (1) and shall submit such reports to the Committee on Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate. The Comptroller General shall provide a copy of each such report to the Network.

“(B) NETWORK.—Not later than 180 days after the date on which a report is submitted under subparagraph (A), the Network shall submit to each of the committees specified in such subparagraph a report describing any actions the Network has taken in response to the report under subparagraph (A).’’

(b) RULE OF CONSTRUCTION.—The amendments made by this Act may not be construed as affecting the duration of the contract under section 372 of the Public Health Service Act that was in effect on the day before the date of the enactment of this Act.

SEC. 4. ADDITIONAL AMENDMENTS.

(a) IN GENERAL.—Part H of title III of the Public Health Service Act (42 U.S.C. 273 et seq.) is amended—

(1) by striking section 373;

(2) in section 374—

(A) in subsection (b)(1), by inserting after “organization” the following: “and other organizations for the purpose of increasing the supply of transplantable organs”;

(B) in subsection (c), by striking “or 373” each place such term appears; and

(C) in subsection (d), by amending paragraph (2) to read as follows:

“(2) The term ‘organ’, with respect to transplantation into humans, means the human or other animal kidney, liver, heart, lung, pancreas, and any other organ (other than human corneas and eyes) specified by the Secretary by regulation. For purposes of section 372(c), such term includes bone marrow.”;

(3) in section 375—

(A) in paragraph (1), by striking “this part” and inserting “this section”; and

(B) in paragraph (4)—

(i) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively; and

(ii) in subparagraph (B) (as so redesignated), by striking “comparative costs and patient outcomes” and inserting “comparative patient outcomes”;

(4) in section 376—

(A) by striking “the Secretary” and inserting “the Organ Procurement and Transplantation Network under section 372”;

(B) by striking “Committee on Energy and Commerce” and inserting “Committee on Commerce”;

(5) by striking section 377.

(b) REDESIGNATIONS.—Part H of title III of the Public Health Service Act, as amended by subsection (a) of this section, is amended by redesignating sections 374 through 376 as sections 373 through 375, respectively.

(c) PERFORMANCE STANDARDS.—Section 371(b)(1) of the Public Health Service Act (42 U.S.C. 273(b)(1)) is amended—

(1) by redesignating subparagraphs (D) through (G) as subparagraphs (E) through (H), respectively;

(2) by moving subparagraph (F) (as so redesignated) two ems to the left; and

(3) by inserting after subparagraph (C) the following:

“(D) notwithstanding any other provision of law, has met the other requirements of this subsection and has been certified or recertified by

the Secretary as meeting the performance standards to be a qualified organ procurement organization through a process which—

“(i) granted certification or recertification within the previous 4 years with such certification in effect as of October 1, 1999, and remaining in effect through the earlier of—

“(I) January 1, 2002, or

“(II) the completion of recertification under the requirements of clause (ii); or

“(ii) is defined through regulations promulgated by the Secretary not later than January 1, 2002, which—

“(I) require recertifications of qualified organ procurement organizations not more frequently than once every 4 years;

“(II) rely on performance measures that are based on empirical evidence of organ donor potential and other related factors in each service area of qualified organ procurement organizations;

“(III) provide for the filing and approval of a corrective action plan by a qualified organ procurement organization that fails to meet the performance standards and a grace period of not less than 3 years during which such organization can implement the corrective action plan without risk of decertification; and

“(IV) provide for a qualified organ procurement organization to appeal a decertification to the Secretary on substantive and procedural grounds.”

SEC. 5. PAYMENT OF TRAVEL AND SUBSISTENCE EXPENSES INCURRED TOWARD LIVING ORGAN DONATION.

Part H of title III of the Public Health Service Act, as amended by section 4(b) of this Act, is amended by inserting after section 375 the following section:

“PAYMENT OF TRAVEL AND SUBSISTENCE EXPENSES INCURRED TOWARD LIVING ORGAN DONATION

“SEC. 376. (a) **IN GENERAL.**—The Secretary may make awards of grants or contracts to States, transplant centers, qualified organ procurement organizations under section 371, or other public or private entities for the purpose of—

“(1) providing for the payment of travel and subsistence expenses incurred by individuals toward making living donations of their organs (in this section referred as ‘donating individuals’); and

“(2) in addition, providing for the payment of such incidental nonmedical expenses that are so incurred as the Secretary determines by regulation to be appropriate.

“(b) **ELIGIBILITY.**—

“(1) **IN GENERAL.**—Payments under subsection (a) may be made for the qualifying expenses of a donating individual only if—

“(A) the State in which the donating individual resides is a different State than the State in which the intended recipient of the organ resides; and

“(B) the annual income of the intended recipient of the organ does not exceed \$35,000 (as adjusted for fiscal year 2001 and subsequent fiscal years to offset the effects of inflation occurring after the beginning of fiscal year 2000).

“(2) **CERTAIN CIRCUMSTANCES.**—Subject to paragraph (1), the Secretary may in carrying out subsection (a) provide as follows:

“(A) The Secretary may consider the term ‘donating individuals’ as including individuals who in good faith incur qualifying expenses toward the intended donation of an organ but with respect to whom, for such reasons as the Secretary determines to be appropriate, no donation of the organ occurs.

“(B) The Secretary may consider the term ‘qualifying expenses’ as including the expenses of having one or more family members of donating individuals accompany the donating indi-

viduals for purposes of subsection (a) (subject to making payment for only such types of expenses as are paid for donating individuals).

“(c) **LIMITATION ON AMOUNT OF PAYMENT.**—

“(1) **IN GENERAL.**—With respect to the geographic area to which a donating individual travels for purposes of subsection (a), if such area is other than the covered vicinity for the intended recipient of the organ, the amount of qualifying expenses for which payments under such subsection are made may not exceed the amount of such expenses for which payment would have been made if such area had been the covered vicinity for the intended recipient, taking into account the costs of travel and regional differences in the costs of living.

“(2) **COVERED VICINITY.**—For purposes of this section, the term ‘covered vicinity’, with respect to an intended recipient of an organ from a donating individual, means the vicinity of the nearest transplant center to the residence of the intended recipient that regularly performs transplants of that type of organ.

“(d) **RELATIONSHIP TO PAYMENTS UNDER OTHER PROGRAMS.**—An award may be made under subsection (a) only if the applicant involved agrees that the award will not be expended to pay the qualifying expenses of a donating individual to the extent that payment has been made, or can reasonably be expected to be made, with respect to such expenses—

“(1) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

“(2) by an entity that provides health services on a prepaid basis.

“(e) **DEFINITIONS.**—For purposes of this section:

“(1) The term ‘covered vicinity’ has the meaning given such term in subsection (c)(2).

“(2) The term ‘donating individuals’ has the meaning indicated for such term in subsection (a)(1), subject to subsection (b)(2)(A).

“(3) The term ‘qualifying expenses’ means the expenses authorized for purposes of subsection (a), subject to subsection (b)(2)(B).

“(f) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there is authorized to be appropriated \$5,000,000 for each of the fiscal years 2000 through 2005.”

SEC. 6. PUBLIC AWARENESS; STUDIES AND DEMONSTRATIONS.

Part H of title III of the Public Health Service Act, as amended by section 5 of this Act, is amended by inserting after section 376 the following section:

“PUBLIC AWARENESS; STUDIES AND DEMONSTRATIONS

“SEC. 377. (a) **PUBLIC AWARENESS.**—The Secretary shall (directly or through grants or contracts) carry out a program to educate the public with respect to organ donation, including the need to provide for an adequate rate of such donations.

“(b) **STUDIES AND DEMONSTRATIONS.**—The Secretary may make grants to public and non-profit private entities for the purpose of carrying out studies and demonstration projects with respect to providing for an adequate rate of organ donation.

“(c) **ANNUAL REPORT TO CONGRESS.**—The Secretary shall annually submit to the Congress a report on the activities carried out under this section, including provisions describing the extent to which the activities have affected the rate of organ donation.

“(d) **AUTHORIZATION OF APPROPRIATIONS.**—

“(1) **IN GENERAL.**—For the purpose of carrying out this section, there are authorized to be appropriated \$10,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2005. Such authorization of appropriations is in addition to any other authorizations of appropriations that is available for such purpose.

“(2) **STUDIES AND DEMONSTRATIONS.**—Of the amounts appropriated under paragraph (1) for a fiscal year, the Secretary may not obligate more than \$2,000,000 for carrying out subsection (b).”

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

Section 378 of the Public Health Service Act (42 U.S.C. 274g) is amended to read as follows: “AUTHORIZATION OF APPROPRIATIONS FOR ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK

“SEC. 378. (a) **OPERATION OF NETWORK.**—For the purpose of providing for the Organ Procurement and Transplantation Network under section 372, including the scientific registry, there are authorized to be appropriated \$6,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2005.

“(b) **INCREASING ORGAN DONATION AND PROCUREMENT.**—For the purpose of increasing organ donation and procurement through the Organ Procurement and Transplantation Network under section 372, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2000 through 2005. Such authorization of appropriations is with respect to such purpose in addition to the authorization of appropriations established in subsection (a).”

SEC. 8. EFFECTIVE DATE.

The amendments made by this Act take effect October 1, 1999, or upon the date of the enactment of this Act, whichever occurs later.

The CHAIRMAN. No amendment to that amendment is in order except those printed in House Report 106-557. Each amendment may be offered only in the order printed in the report, by a Member designated in the report, shall be considered read, shall be debatable for the time specified in the report, equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question.

The Chairman of the Committee of the Whole may postpone a request for a recorded vote on any amendment and may reduce to a minimum of 5 minutes the time for voting on any postponed question that immediately follows another vote, provided that the time for voting on the first question shall be a minimum of 15 minutes.

It is now in order to consider amendment No. 1 printed in House Report 106-557.

AMENDMENT NO. 1 OFFERED BY MS. DEGETTE

Ms. DEGETTE. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 1 offered by Ms. DEGETTE: Page 8, strike lines 11 through 14 and insert the following:

“(10) The Network shall recognize the differences in health and in organ transplantation issues between children and adults throughout the system and adopt criteria, policies, and procedures that address the unique health care needs of children.

Page 29, line 18, redesignate section 8 as section 9 and insert after line 17 the following:

SEC. 7. STUDY REGARDING IMMUNOSUPPRESSIVE DRUGS.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall provide for a

study to determine the costs of immunosuppressive drugs that are provided to children pursuant to organ transplants and to determine the extent to which health plans and health insurance cover such costs. The Secretary may carry out the study directly or through a grant to the Institute of Medicine (or other public or nonprofit private entity).

(b) RECOMMENDATIONS REGARDING CERTAIN ISSUES.—The Secretary shall ensure that, in addition to making determinations under subsection (a), the study under such subsection makes recommendations regarding the following issues:

(1) The costs of immunosuppressive drugs that are provided to children pursuant to organ transplants and to determine the extent to which health plans, health insurance and government programs cover such costs.

(2) The extent of denial of organs to be released for transplant by coroners and medical examiners.

(3) The special growth and developmental issues that children have pre- and post-organ transplantation.

(4) Other issues that are particular to the special health and transplantation needs of children.

(c) REPORT.—The Secretary shall ensure that, not later than December 31, 2000, the study under subsection (a) is completed and a report describing the findings of the study is submitted to the Congress.

The CHAIRMAN. Pursuant to House Resolution 454, the gentlewoman from Colorado (Ms. DEGETTE) and a Member opposed each will control 5 minutes.

Mr. BLILEY. Mr. Chairman, I am not in opposition to the amendment, but I claim the time in opposition.

The CHAIRMAN. Without objection, the gentleman from Virginia (Mr. BLILEY) will control the time in opposition.

There was no objection.

The CHAIRMAN. The Chair recognizes the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this amendment addresses an important and often forgotten aspect of organ transplantation, pediatric organ transplantation. The first part of the amendment is technical in nature and it amends an amendment that I passed in voice vote in the Committee on Commerce which requires the Organ Transplantation Network to adopt criteria, policies, and procedures that address the unique health care needs of children with respect to pretransplantation mortality rates.

Presently, children constitute the vast minority of organ transplantation cases as children tend to be healthier and less in need of organ transplants than adults. Despite this, however, the pretransplantation mortality rate among children in 1998 was much higher, an estimated 55 percent higher than adults. According to the United Network for Organ Sharing or UNOS, quote, among very young children, the death rates were much higher than for other children or adults, particularly on the liver, heart, and lung waiting lists.

However, because children have unique health, growth and developmental issues prior to transplantation and post-transplantation, the language needs to be broader than the amendment we passed in the Committee on Commerce. Therefore this portion of the amendment simply strikes the language specifically addressing children's unique needs in the pretransplantation period, making it more general to the full range of organ transplantation.

This new language has the full support of the entire pediatric organ transplantation community across the country, including the National Association of Children's Hospitals, the American Academy of Pediatrics, and the American Society of Pediatric Nephrology. Consumer groups and others in the organ transplantation field, including the American Society for Transplantation and UNOS are also supportive. In fact, I know of no stated opposition to the new language; and it is something that the proponents of this legislation can and I believe do support.

The second part of the amendment, Mr. Chairman, would require a study of the unique health care needs of children, including growth and developmental issues and immunosuppressive drug coverage in organ transplantation. This study will follow up on a congressionally mandated study of immunosuppressive drug coverage for the Medicare population which, obviously since it was the Medicare population, largely does not address children.

Mr. Chairman, this is the study that was done. Only a very small percentage of this study addressed kids and in that case only a very small percent of children's transplantation. The other seminal study in the field does not address pediatric organ transplantation at all. Given the fact that a substantially higher percentage of children who are on pediatric lists are dying, I think it is essential that we complete these studies and that we complete them soon. The study will give a more complete picture of the full range of problems in pediatric organ transplantation and will give us invaluable assistance as we move down the road and try to figure out what an allocation is.

Mr. Chairman, I urge the adoption of this important amendment to improve the lives of children across the country who are in need of organ transplants.

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

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in support of this amendment. This amendment is similar to one offered and accepted in committee by the gentlewoman from Colorado. This amendment ensures that our Nation's organ transplantation system recognizes our children's unique health care needs. This provision provides for a study of immuno-

suppressive drug coverage for children and on children's unique growth, developmental health and organ transplant needs.

As many of my colleagues know, at the end of the last session, the House passed H.R. 3075, the Medicare, Medicaid and S-CHIP Balanced Budget Refinement Act of 1999. Due to Committee on Commerce efforts, this bill was strengthened by adding \$200 million to pay for immunosuppressive drugs needed by organ transplant patients to prevent their body from rejecting the new organ. Medicare currently only covers these drugs for 36 months. This bill took a first step at addressing that issue and allows us to provide more coverage for needy organ transplant patients. Access to these drugs can literally make the difference between life and death.

It is time we extend our efforts to America's children and recognize their unique organ transplant needs. I urge my colleagues to support the amendment.

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

Ms. DEGETTE. Mr. Chairman, I am delighted to yield whatever time I may have remaining to my colleague, the gentleman from Pennsylvania (Mr. PETERSON) who has been a real partner with me on these pediatric transplant organ issues and to whom I owe a lot of thanks.

The CHAIRMAN pro tempore (Mr. EWING). The gentleman from Pennsylvania (Mr. PETERSON) is recognized for 1½ minutes.

Mr. PETERSON of Pennsylvania. Mr. Chairman, I thank the gentlewoman from Colorado for her fine work on this bill. It was a delight to work with her and her staff as we introduced it just a short time ago. I would like to thank the gentleman from Virginia for his acceptance and his support of this amendment, because it is vital.

When we stop and think about it, little children whose organs are still growing, it really is a different medical situation than it is with adults like ourselves where our organs are finished growing. It makes a difference what type of organ they get more than it does with adults.

It is more important that we do it right with children who have a whole life ahead of them, not just a couple of years but a whole life. As we heard the sad story a short while ago, I think the gentleman from Oregon or Wisconsin, I forget which it was, who lost his son because a heart was not available, I think it is important that an emphasis be put, that the studies be done, that we analyze the needs of children, that we know exactly what works best from the experts who do it and that we make sure that we follow all of those guidelines, that we make sure we get those children's organs to children when possible and we give them their very best

chance at living an entire life because of that organ.

Mr. Chairman, this whole debate today is about extending life and delaying death, with children and with adults. We need to have the very best medical evidence possible as we make each and every one of those decisions.

Mr. BLILEY. Mr. Chairman, I urge the adoption of the amendment.

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

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentlewoman from Colorado (Ms. DEGETTE).

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

Mr. LAHOOD. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, further proceedings on the amendment offered by the gentlewoman from Colorado (Ms. DEGETTE) will be postponed.

The CHAIRMAN pro tempore. It is now in order to consider amendment No. 2 printed in House Report 106-557.

AMENDMENT NO. 2 OFFERED BY MR. LUTHER

Mr. LUTHER. Mr. Chairman, I offer an amendment.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 offered by Mr. LUTHER: Page 8, after line 14, insert the following subsection (and redesignate subsequent subsections accordingly):

“(C) COMPLIANCE WITH ORGAN ALLOCATION POLICIES.—No State or local governing entity shall establish or continue in effect any law, rule, regulation, or other requirement that would restrict in any way the ability of any transplant hospital, organ procurement organization, or other party to comply with organ allocation policies of the Network.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, the gentleman from Minnesota (Mr. LUTHER) and the gentleman from Virginia (Mr. BLILEY) each will control 5 minutes.

The Chair recognizes the gentleman from Minnesota (Mr. LUTHER).

Mr. LUTHER. Mr. Chairman, I yield myself 2½ minutes.

Mr. Chairman, first let me thank the gentleman from California (Mr. DREIER), the gentleman from Massachusetts (Mr. MOAKLEY), and the Committee on Rules for making this amendment in order.

This amendment is very simple. It prohibits State and local laws from interfering with the allocation policies of the National Organ Transplant Network. In particular, the amendment addresses what has become known as organ hoarding laws in this country. These laws mandate that organs procured within a particular State must stay within that particular State. They contradict the very purpose behind a national system of organ procurement

and allocation. This amendment ensures that medical science, not local politics, determines who shall receive a precious organ in this country.

In 1984, Congress enacted the National Organ Transplantation Act in order to create a national system, and I emphasize national, whereby organs are allocated on the basis of medical necessity and compatibility, not on geographic residence.

□ 1300

Since then, organ procurement organizations across the country have endeavored to cooperate with each other in local sharing arrangements. They have largely served patients well; however, in the last 3 years, seven States in our country have passed organ hoarding laws, the consequences of which could be absolutely devastating.

These laws dictate that a less needy patient in the home State could actually have priority over a patient with greater need in another State.

Whether you are on the side of HHS or UNOS in this ongoing battle, such an outcome is at complete odds with the very purpose of our national system. And it undermines the cooperative spirit transplant centers have developed across the Nation.

I want to make it clear, this amendment in no way affects the power struggle between the transplant community and the Department of Health and Human Services. It would not affect the local sharing agreements between procurement organizations. In fact, the amendment ensures that such arrangements remain intact and retain their medical authority.

In this debate, instead of focusing on where we disagree, let us focus on where we agree. Mr. Chairman, local politics should play no role in this important matter. Let doctors and transplant experts make the decisions on organ allocation in this country.

I urge Members to support this simple amendment.

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

Mr. BLILEY. Mr. Chairman, I yield myself such time as I consume.

Mr. Chairman, this amendment is rather simple in its effect. It would eliminate those State laws giving priority for citizens in a given State before an organ would be transferred across State lines for someone else.

These laws were passed as a response to the administration's very controversial regulation of April 2, 1998. Many States that have invested time, talent, and treasure to increase their donation rates saw in the Secretary's new policies a drive to take away the fruit of their labors. In order to protect their citizens from an unfair rule, States started passing laws giving their citizens a right of first refusal for organs available.

My answer to my colleagues who oppose these State laws is that these laws

would not be in effect had the Secretary of HHS not tried to overturn 16 years of deliberations over organ policymaking.

I ask my colleagues to vote no on the amendment of the gentleman from Minnesota (Mr. LUTHER).

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

Mr. LUTHER. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Chairman, I thank the gentleman from Minnesota (Mr. LUTHER) for yielding me this time.

Mr. Chairman, I live in a State that has two organ centers, Philadelphia and Pittsburgh, both near the State lines. There are many States that have large centers very near State lines.

Should a person's determination of whether they get an organ when they truly need one depend whether they live 5 miles down the road in the wrong State? Think about it. What if you live in the wrong State?

I commend the States that have done a better job. Part of it, to be fair, is because they have younger populations. They have more accidents where young people die and organs are usable. Part of it is that, and part of it may be that they have a better system. I commend them. And we need to increase that system so we do not have a shortage.

We should not have a system that would deny someone life and give them death because they lived 5 miles across the State line.

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

I would answer the last speaker by simply saying what the gentleman from Oklahoma (Mr. ISTOOK) said earlier under general debate, are we going to give authority over body parts of the dead to the Federal Government?

I do not think we want to do that. We have had a program that has worked well for 16 years. We have had States that have been very aggressive in obtaining donors. Why should they be punished to take care of populations in other States that have not been as aggressive? I think that we should reject this amendment.

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

Mr. LUTHER. Mr. Chairman, I yield myself such time as I may consume.

I will be very brief. The battle that is going on between the Department of Health and Human Services and UNOS is very unfortunate. I think it is terrible when an issue as serious as this has gotten involved in the kind of controversy that it is currently involved in. UNOS does terrific work in this country, and the people and the Department of Health and Human Services are very well-intentioned.

What we need to do is rise above that, as Members of this Congress; and we need to recognize that life and

death does not know geographical boundaries. Organs do not know geographical boundaries.

Let us let the experts, the medical professionals, make these decisions. Let us not have someone not get an organ in this country because they happened to be on the other side of a geographical boundary and some decision was made that controls over medical science in this country. That is why I offer this amendment.

I ask my colleagues to support this amendment and bring a better rational system to this country than this underlying bill would bring if it would be passed by this body.

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

The CHAIRMAN pro tempore (Mr. EWING). The question is the amendment offered by the gentleman from Minnesota (Mr. LUTHER).

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

Mr. BLILEY. Mr. Chairman, I demand a recorded vote.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, further proceedings on Amendment No. 2 offered by the gentleman from Minnesota (Mr. LUTHER) will be postponed.

It is now in order to consider Amendment No. 3 printed in House Report 106-557.

AMENDMENT NO. 3 OFFERED BY MR. LAHOOD

Mr. LAHOOD. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 3 offered by Mr. LAHOOD:

Page 14, strike line 21 and all that follows through page 17, line 17, and insert the following:

“(h) CERTAIN SCIENTIFIC AND ADMINISTRATIVE PRINCIPLES.—

“(1) SCIENTIFIC PRINCIPLES.—Policies under subsection (b) for the allocation of organs—

“(A) shall be based on sound medical principles;

“(B) shall be based on valid scientific data;

“(C) shall be equitable and seek to achieve the best use of donated organs;

“(D) shall be designed to avoid wasting organs, to avoid futile transplants, to promote patient access to transplantation, and to promote the efficient management of organ placement;

“(E) shall be specific for each organ type or combination of organ types;

“(F) shall, where appropriate for the specific organ, provide status categories that group transplant candidates from most to least medically urgent;

“(G) shall not use patient waiting time as a criterion unless medically appropriate; and

“(H) shall be designed to share organs over as broad a geographic area as feasible, consistent with subparagraphs (A) through (G).

“(2) PATIENT LISTING AND STATUS.—Policies under subsection (b) for listing patients shall address the suitability of patients for transplants, appropriate priority status of each candidate, and the situations for removing candidates from the waiting list. Such policies shall be uniform for each organ type, objective, and medically appropriate.

“(3) REVIEW AND APPROVAL OF POLICIES; CONSISTENCY WITH SCIENTIFIC PRINCIPLES.—The policies and rules established by the Network shall be subject to review and approval by the Secretary (after consultation with the advisory committee under paragraph (4)), and no policy or rule established under subsection (b) may be inconsistent with paragraph (1) or (2). The applicability of sanctions under subsection (g) to any Network participant is subject to review and approval by the Secretary.

“(4) INDEPENDENT SCIENTIFIC REVIEW.—The Secretary shall establish (consistent with the Federal Advisory Committee Act) an advisory committee to provide recommendations to the Secretary on the policies and rules of the Network, and on such other matters as the Secretary determines to be appropriate.

“(5) PATIENT LISTING AND OTHER FEES.—

“(A) AVAILABILITY; RESTRICTION.—Fees collected by the Network—

“(i) are available to the Network, without fiscal year limitation, for use in carrying out the functions of the Network under this section; and

“(ii) may not be used for any activity for which contract funds awarded under subsection (a) may not be used.

“(B) APPLICABILITY.—Subparagraph (A) applies only to patient listing fees of the Network and to fees imposed as a condition of being a Network participant, and such fees are subject to the approval of the Secretary. Such subparagraph does not prohibit the Network from collecting other fees and using such fees for purposes other than those specified in such subparagraph.

“(C) GIFTS.—This section does not prohibit the Network from accepting gifts of money or services, including for purposes other than those specified in subparagraph (A). The Network may accept gifts of money or services to carry out activities to provide for an increase in the rate of organ donation.

“(6) INFORMATION.—The Network shall provide to the Secretary such information and data regarding the Network and Network participants as the Secretary determines to be appropriate. The Network shall provide data in a timely manner, with suitable patient confidentiality protections, to independent investigators and scientific reviewers.

“(7) LIMITATION ON AMOUNT OF CONTRACT.—The amount provided under a contract under subsection (a) in any fiscal year may not exceed \$6,000,000 for the operation of the Network, including the scientific registry under subsection (c). Such limitation does not apply to amounts provided under the contract for increasing organ donation and procurement.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, the gentleman from Illinois (Mr. LAHOOD) and the gentleman from Virginia (Mr. BLILEY) each will control 30 minutes.

The Chair recognizes the gentleman from Illinois (Mr. LAHOOD).

Mr. LAHOOD. Mr. Chairman, I yield myself such time as I may consume.

We are offering this amendment to prevent a very bad piece of legislation from going forward today. This bill, in essence, would set up a single-source agency to make all of the determinations about where transplanted organs would go. That is very, very bad public policy. It is bad public policy because no one agency should be in charge of

such an important medical procedure and such an important aspect of health care in America today.

Mr. Chairman, we have had a good system. I know it is very in vogue and very favorable to talk in bad terms about bureaucrats and to label HHS a very bureaucratic agency, but who will look after the taxpayers' dollars? Who will look after how the money is being spent? If it is not HHS, it will be no one. This bill allows for one agency to have total control over the transplants, over the procedures, over the organs and have no accountability to anybody, and that is wrong. We should not allow that kind of public policy to pass this House of Representatives.

Mr. Chairman, our amendment, which has strong support from some very distinguished colleagues who will speak on it, would make several recommendations made by the Institute of Medicine, which did a study on the organ allocation process, and it ensures that organ allocation policies are based on sound medical principles and valid scientific data.

Now, is there anybody here that does not believe that HHS has that kind of capability? Because they are a part of the Federal bureaucracy, does that mean they do not have capable people? Of course they do. They have as capable people medically as any agency or any program anywhere in the country. They can make good decisions. There should be some oversight. To hand this over to one agency that will have God-like powers to tell everybody in America who can get an organ and who cannot will revert back to an old system where favorable people and prominent people will get the organs and common, ordinary citizens will be left behind to die. That is wrong. I do not think anybody in this House wants that kind of policy.

Now, I have a letter here that was referred to earlier that actually is from the UNOS agency, and what they are saying in the first paragraph, the letter is to the gentleman from Michigan (Mr. DINGELL), and what it says is that “we are working with HHS.” This letter is dated March 15, and it simply says, “we are working with HHS. Congress do not need to pass any legislation, we do not need legislation. We are working with HHS and UNOS to try and work out an agreeable kind of a program.”

Why pass legislation to give favorable consideration to one agency? For what purpose? I do not know, except that somebody has favorable consideration from certain Members of Congress around here. This is bad public policy.

There is also a letter from the Department of Justice, and I will make these a part of the RECORD when we go back into the House, that says that with regard to the relationship between the Secretary, meaning the Secretary of HHS, and the network, the

bill provides that administrative and procedural functions for the network shall be carried out in accordance with mutual agreement of the Secretary and the network.

So there has to be some kind of a relationship. We cannot give one agency carte blanche, say, over these kinds of procedures and transplants.

There is also a letter from OMB, which I will also make a part of the RECORD, which simply says that there are things being worked out by the administration and by UNOS, and they are going to veto this bill if it would ever see the light of day, which it probably will not in the Senate; but we should not have Members voting on such lousy, bad policy.

Now, if my colleagues do not believe all of that and if they do not agree with my argument, then what we ought to do is have Members call back to their hospitals, call back to their local health providers. They will tell my colleagues that they do not want one agency in America deciding these things; they want some oversight. So if my colleagues do not believe me, then call back to the local providers who provide these transplant capabilities in their own districts, and they will find out what the truth is.

No single agency should have this kind of power. If we want to revert back to the old ways of doing things where prominent people in America get these transplants, then vote for this legislation. If we want to have a good system with oversight, vote for the LaHood-Moakley-Rush-Peterson amendment, which does an awful lot to maintain credibility and honesty and integrity.

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

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this amendment is a radical departure from 16 years of congressional legislation on organs. It would make all organ procurement and transplantation network policies and rules subject to review and approval by the Secretary. This flies in the face of the present statute.

The LaHood-Moakley amendment is not just a little amendment to H.R. 2418, it is a gutting amendment. It overturns 16 years of deliberation by the Nation's top transplantation experts who have labored and debated over the most complicated issues any person would ever encounter and turns it over to the whims of the Secretary. Just imagine if you were put in the shoes of being Secretary of HHS under the LaHood amendment with no prior awareness or experience in this area.

Organ allocation is a very difficult task. There are no easy answers. The hard truth is that there are not enough organs available for people who need them. A poll conducted a few months after the administration's organ regu-

lation was released yesterday by an advocacy group found that Americans hold very strong opinions on what they believe to be fair organ allocation policies.

The problem is that some of those opinions seem contradictory. The poll found that 83 percent agreed that an organ from a donor should go to the sickest patient in the U.S., no matter where they live, under our national sickest-first policy. Status one patients who are under intensive care and who may die within a week would have priority. Those with a greater chance of survival would not enjoy the same access to organs.

That number may have been much less if people were informed about the direct relationship between increased organ delivery time and the likelihood of organ rejection.

□ 1315

While expressing preference for the "sickest first" poll, respondents also believe organs should be transplanted into patients with the best chance of surviving surgery. Those with the best chance of surviving are the so-called Status 3 patients, who are terminally ill but do not need hospitalization. If this preference were followed, Status 1 patients would not be preferred to receive lifesaving organs nor would the intermediate Status 2A and Status 2B patients.

It is the less sick Status 3 patients who have the best chance of surviving with a transplant and the lowest chance of rejecting the transplanted organ. This preference contradicts the first one.

To complicate the story further, the "sickest first" policy was not the top choice of respondents. In fact, 86 percent want those patients who have been on a waiting list the longest to get an organ. After all, what could be more fair than waiting in line and taking turns? This response is very embarrassing to the organizations that paid for the poll, because the so-called first-in, first-out policy comes down on the other side of the "sickest first."

The most popular preference would have the unintended consequence of giving organs to those who could survive the longest without a transplant. Thus, some of the sickest patients would die, contrary to the "sickest first" preference held by the same group.

These inconsistent polling results call to mind a quotation by Edmund Burke: "Your representative owes you not only his industry but his judgment, and he betrays, instead of serving you, if he sacrifices it to your opinion."

No President, no legislature, no judge, and certainly no bureaucracy has the competence to make the life and death decisions for allocating organs. There are too many competing scientific and ethical considerations

for government to devise a fair system to allocate too few organs among too many people.

America needs a special institution to sort through people's competing passions and positions and to render a sensible and well-informed decision. That is why Congress clearly put this decision-making into the hands of those who know best, the transplant community. When Congress passed the National Organ Transplant Act, it established a private entity to coordinate a consensus position within that community.

But the system that has grown under the watchful eye of the entire transplant community ought not be uprooted by regulatory whim or bumper sticker slogans. Vote "no" on the LaHood-Moakley amendment.

Mr. LAHOOD. Mr. Chairman, I yield 3½ minutes to the gentleman from Chicago, Illinois (Mr. RUSH).

Mr. RUSH. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I rise in strong support of the amendment sponsored by myself, the gentleman from Illinois (Mr. LAHOOD), the gentleman from Massachusetts (Mr. MOAKLEY), and the gentleman from Pennsylvania (Mr. PETERSON).

Mr. Chairman, this amendment is designed to put some accountability back into the organ donation and allocation system, accountability which the bill before us, H.R. 2418, would eliminate.

Mr. Chairman, this bill, H.R. 2418, is indeed bad policy. It is an atrocious bill that will further exacerbate the misfortunes of many of America's citizens.

In the last 2 years, the U.S. Department of Health and Human Services has made several attempts to implement a new organ donation and allocation regulation designed to improve the system of organ allocations in the country. The HHS regulation incorporates many of the sound recommendations of the National Academy of Sciences' Institute of Medicine's recommendations for improving the organ donation and allocation system.

This regulation, the subject of opposition by those groups which would maintain the status quo, has twice been delayed by congressional action.

Finally, last month, the regulation went into effect. Not one month later, this House is debating a bill that would vitiate all of the public good intended by the rule.

Mr. Chairman, the HHS regulation directs the national organ donation and allocation contractor to revise its rules to provide for broader organ sharing. The regulation permits the Secretary to revise any proposed rules that are deemed inappropriate.

Most of the debate about the HHS regulation has been focused on the allocation section and the Secretary's

authority to review any new allocation policies.

In Illinois, we are fortunate to have nine transplant centers which perform 745 organ transplants alone. However, despite the work of these centers and a strong organ donation program, the waiting list for transplantation in Illinois grows longer every day.

The new HHS rule would help this situation by authorizing the Secretary to change any regulation that might disadvantage States like Illinois. That is what our amendment does, it guarantees that organ allocation systems would be fair to all, and strike the proper balance between medical judgments and public accountability.

Mr. Chairman, furthermore, I want to say that the Institute of Medicine, in the 1999 report to the Congress, and also Secretary Shalala, have all indicated that women, minorities, and the poor are disadvantaged under this current system. Mr. Chairman, I urge all of my colleagues to support our amendment.

Mr. BLILEY. Mr. Chairman, I yield such time as he may consume to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health and Environment of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Chairman, I thank the gentleman for yielding this time to me.

Mr. Chairman, I would just say to the gentleman from Illinois, who is really a very good friend, and I know there is nothing personal in it, but this atrocious bill, as he calls it, merely basically says that what has taken place over the last 16 years, which everybody basically agrees has been working pretty darned well, not perfectly, that is for sure, will continue to be the case. It is not a power grab on our part, it is a power grab on the part of HHS.

We are basically saying what has worked and worked well, keep it in place. Despite the fact, Mr. Chairman, that NOTA neither explicitly nor implicitly delegates policy-making authority to the HHS Secretary, she has promulgated, and after three congressional moratoria, implemented regulations which assume just such authority.

Under her final rule, which became effective on March 16, she claims the authority to overrule or even rewrite national organ transplant policy. The last time I checked, Secretary Shalala, with all due respect, is not carrying a medical license.

No president, no legislature, and no Federal bureaucracy is competent to make the complicated medical and ethical decisions required to allocate organs for transplantation. To foster public trust, it is important that allocation remain one step removed from the political sphere. That is what Congress intended in 1984. That is the way it has been all along until just the last

couple of years. We should ask ourselves, what has happened just in the last couple of years that requires supposedly some sort of a change?

The OPTN is made up of physicians, of patients, and other transplant community representatives. It is not an agency, as has been mentioned here by the gentleman from Illinois (Mr. LAHOOD) a couple of times, more than once. It is not an agency. They and not Secretary Shalala know best when it comes to deciding transplant policies. Their careful, deliberate decisions should not be uprooted by regulatory whim.

Let us not be misled, Mr. Chairman. Although the Secretary does not have policy-making authority under current law nor under H.R. 2418, the Secretary does have adequate authority to oversee compliance of the network. Under current law, the Secretary has significant power over the contractor which runs the network. The Secretary created the network, if you will. The Secretary determined that UNOS would be the private entity that would be responsible for this.

The Secretary drafts the terms and conditions of the contract which set forth the administrative responsibilities of the network, and will ensure that the network complies with the obligations of the statute. If the contractor does not comply with the terms of the contract, there are a number of remedies, including, if appropriate, use of the False Claims Act and government contracting remedies.

Furthermore, the Secretary retains the authority, authority to terminate the contract. The Secretary retains the authority to terminate the contract. Under this bill, the Secretary shall conduct public hearings and receive comments from the public about the performance of the network.

In addition, the General Accounting Office shall conduct, under the bill, required regular evaluations of the network to ensure that it is complying with the terms of the statute. So if UNOS is not doing the job adequately, the Secretary now has the authority to do something about it. The Secretary has the authority to do something about it.

What would the LaHood amendment do? It would require policies to be designed to allocate organs "in order of decreasing medical urgency status over the largest geographic area, so that neither place of residence nor place of listing shall be a major determinant."

Even HHS has admitted in the preamble to the rule that this policy, that this policy, would reduce survival rates and the number of patients transplanted, while increasing organ waste and transplant costs. Even HHS admits that that policy would do that.

It would also require that kidneys be allocated to patients solely on the basis of waiting time, and that inter-

transplant waiting time variance be as small as possible.

There are a lot of things that this does. I am here to tell the Members, just finishing it up, the LaHood-Rush amendment, the substitute, completely surrenders all policy-making authority to the HHS Secretary and mandates allocation to the sickest patients first on a national list. Now that is mandated on a local, if you will, or in a regional list, but that would mandate it on a national list.

If it is possible to draft a bill that gives even more power to Secretary Shalala over organ transplant policies than her final rule, then the gentlemen from Illinois, Mr. LAHOOD and Mr. RUSH, with all due respect, have done just that.

Mr. LAHOOD. Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. WAXMAN), a distinguished member of the committee.

Mr. WAXMAN. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I think this proposal, this amendment, is a very constructive one. I think it meets a lot of the concerns that have been expressed on all sides on this issue.

After the Secretary of HHS proposed regulations that many people fear would be deciding the allocation system from the top down, rather than have the decisions by the medical people who work on these issues day-to-day, the Institute of Medicine looked at the matter. They gave us some recommendations.

The LaHood amendment adopts the recommendations of the Institute of Medicine. It in effect says that we ought to ensure that the bill reflects the best scientific and medical thinking on the issue of organ transplantation. Then, in terms of public accountability, they recommended an independent board to oversee the system, which is what is in the LaHood amendment.

I just want to read to the Members from an organization, the American Liver Foundation. They represent the beneficiaries of transplantation.

They say that, in their view, "It is important to continue to balance the interests, on the one hand, for physicians to make medical decisions, but also for the Federal government to address and provide leadership regarding matters of equity and fairness. ALF," the American Liver Foundation, "would therefore not support the elimination of an oversight role for the Federal government. At the same time, we would stress the importance of establishing a prestigious and independent advisory body to help resolve disputes that may arise between the transplantation network and the Federal government."

The LaHood amendment I think is the answer to concerns that everyone

has expressed on this issue. It would provide commonsense and scientific decisions made by the medical experts. I would urge my colleagues to support the LaHood-Rush-Moakley-Peterson amendment.

Mr. BLILEY. Mr. Chairman, I yield 4 minutes to the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, let me just be brief. This is a gutting amendment. If Members are against States' rights, if they want to turn this over to the Department of Health and Human Services, to the political appointees to run this process, then they should support this amendment.

But if Members are in favor of States doing a good job in administering their own organ transplant systems, if Members are in favor of incentivizing good States to do a good job in putting their own organ programs together, then they should be against this amendment.

In short, I come from Wisconsin. It is a good State that has done a good job putting our own organ transplant system together. But by passing this amendment and turning this over to the Department of Health and Human Services to be run by political appointees in Washington, we will be basically saying to those States that have done so much work on behalf of the organ transplant community, do not bother. You will not be rewarded for that good behavior.

□ 1330

It will be telling those other States that are not doing a very good job that need room for improvement, they do not have to do well because we are nationalizing the whole system and will go to the lowest common denominator. In short, the LaHood-Rush amendment incentivizes the States that need to do better to not do better. It places a disincentive on the States that are doing a good job to cease from doing that good job that they are doing.

We need to let States experiment. We need to let States do a better job and, more importantly, let us let the medical professional people decide how this is done. Let us make sure that organ transplant decisions are going to be exercised by medical professionals, by the data, by scientific research, by physicians, not by political appointees in Washington.

The problem with this amendment is that it will turn over every bit of decision-making to the Department of Health and Human Services, and I only ask my colleagues to take a look at what they are doing to the Medicare program today. All of us see the problems that we are experiencing in Medicare today, much of which comes from the Department of Health and Human

Services; their lack of responsiveness to problems we have in Medicare. We do not want to subject a very life-saving, important, timely issue such as organ transplants to the Department of Health and Human Services to be subject to the same kind of bureaucratic ineptitude that Medicare is now suffering from.

In short, Mr. Chairman, I urge a no vote on this amendment. I believe the sponsors are very well intended. I think that their intentions are good, but I think the logic behind this amendment is very bad. It will penalize the States that are doing well, and it will do nothing to help the States that need room for improvement. And the net result will be less organs to go around, on average, throughout the country.

So I urge defeat of this amendment and passage of 2418 because that will do everything to continue to build on the success we have and the success we have been reaching through other States.

Mr. LAHOOD. Mr. Chairman, I yield 3 minutes to the gentleman from Michigan (Mr. DINGELL), the dean of the House and the ranking member of the Committee on Commerce.

Mr. DINGELL. Mr. Chairman, I rise in support of the LaHood-Moakley-Rush-Peterson amendment. It is a commonsense measure, and it is one which sees to it that we implement the principles that were recommended by the Institute of Medicine in response to a congressional instruction to review organ allocation issues. In a nutshell, all this amendment does is say the Department of Health and Human Services shall exercise legitimate oversight responsibilities assigned to it by the National Organ Transplant Act as articulated in the Final Rule in order to manage the system of organ procurement and transplantation in the public interest.

Now, this has been a day when the smell of red herrings has hung rich in this Chamber. We have heard talk about how there is going to be a huge number of bureaucrats from the Federal Government telling UNOS what to do. The simple fact of the matter is, UNOS is a contractor which is paid in part by the Federal Government to do its job. The simple fact of the matter is that UNOS has not done a very good job. The request from the Secretary of HHS is for them to simply examine and to come forward with regard to allocation of organs.

Now, why is this necessary? Let us take a hard look. Let us look at several States. Kentucky, in one center, 38 days is the median waiting time; 226 days is at another. In Louisiana the median waiting time at one center was 18 days while at another it was 260 days. In my own State of Michigan, the numbers were 161 days and 401 days at another center.

People are dying because of that. Without needed transplants, people are not getting their problems addressed. People who should probably rank lower in the priority of things are getting transplants while people who desperately need them and are liable to die without those transplants and are being denied those transplants. That is what this amendment is about. It is to correct a major defect in the bill.

The charge was made that this is a gutting amendment. It is not. It is a perfecting amendment. It is one which permits the government of the United States to see to it that everyone is treated fairly with regard to allocation of organs when they need them, and to assure that to the best degree possible that people who have need of organs and who will die if they do not get them are more likely to get them and less likely to be denied those organs.

It is something which goes to basic fairness. It is also something which sees to it that a contractor is not going to be given an absolute and untrammelled monopoly over the availability of organs to people who will die if they do not get them and also to assure something else, and that is to assure that the contractor is under reasonable scrutiny and supervision so that he will behave in an appropriate and a decent and a responsible fashion in terms of carrying forward its responsibility.

There has never been any attempt by the Secretary of HHS to in any way intrude into scientific judgment. That argument is nothing but a red herring. I urge support of the amendment.

Mr. BLILEY. Mr. Chairman, I yield 5 minutes to the gentleman from Louisiana (Mr. TAUZIN).

Mr. TAUZIN. Mr. Chairman, I would like to submit a written statement of support for the underlying bill.

Mr. Chairman, first of all, let me correct a reference to the Kentucky Transplant Centers on behalf of my good friend, Mr. WHITFIELD. Reference was made to the different waiting times between two of those transplant centers in Kentucky. Both centers are in the same organ procurement area. The difference in the waiting times are actually a result of the different status levels of individuals on the waiting list, such as seriousness of condition, not time on the list, is a determining factor who gets an organ in that area.

An IOM report stated that the aggregate waiting time is in fact a poor measure of equity of treatment in the transplant field, and I would like to correct the record for those reports on the Kentucky centers.

Mr. Chairman, it is important to understand how we got to this amendment today. We got here because the Department has actually held public hearings on a rule that would, in fact, do what this amendment provides, giving the Secretary the power over decisions made in this critically sensitive

and important area of organ transplant allocation.

We got here because the Secretary insisted on moving forward with that rule, despite the fact that 85 percent of those who commented on it objected to it. Nevertheless, the Secretary proceeded with this rule to override the decisions being made by the network, our local doctors and our local communities. Not only had the Department the gall to move forward despite an 85 percent record against this usurpation of Federal Government authority over this sensitive issue but three times this Congress had to pass moratoriums preventing that from happening.

Three times this Congress went on record telling the Secretary to stop what she was doing. Nevertheless, we are now faced with an amendment now that would in fact, although it is cloaked in the form of an amendment, adopt the Secretary's position, despite the moratoriums we have adopted, despite the fact that 85 percent of the people commenting on this authority have commented against the Federal Government taking over this role in its bureaucratic manner that it often does.

Speaking of red herrings, as this bill is progressing through the Congress, as we are indeed fighting this effort of the Federal Government to take over the terribly sensitive and delicate decisions of how organs are allocated in our transplant system, as we are debating it, the Justice Department sends this letter out questioning the constitutionality of the delegation of authority to the network.

Talk about red herrings. This letter appears from the Justice Department saying this may not be constitutional. The Justice Department did not mention that the two cases they cited were over 60 years old. They did not mention that over the last 60 years there have been new cases deciding the capacity of our Congress and our government to delegate authorities to organizations like the network, and in all of those cases the constitutionality of those delegations have been upheld.

For example, in 1984 in the case of *Cospito v. Heckler*, the courts upheld the constitutionality of the Congress delegating the authority to the Joint Commission on Accreditation of Health Care Organizations. In *American Association of Physicians and Surgeons v. Weinberger*, the court upheld the delegation of authority on a statute which delegated professional standards of review organizations with Federal authority over Medicare and Medicaid programs. In *Corum v. Beth Israel Medical Center*, the same thing happened again.

The history of jurisprudence is replete with authority of Congress to delegate the things like our network. The history is replete with judicial judgments in favor of what has been the practice for 16 years of delegation to

doctors and local communities, this very sensitive issue of organ allocation.

Let me say, as my friends have said, the adoption of this amendment would gut this bill. It would destroy the incentives built in here for organ donors to come forward and make organ donor allocations in a way that is fair and sensible and determined on a local basis with the advice of doctors and patients. It would put a government bureaucracy in charge. It is literally the administration's, the Secretary's, position in emperor's clothes and it is a naked attempt at government usurpation of power over this very delicate and sensitive issue that attacks us and taunts us ethically and responsibly at every level.

This is so delicate, so important. Why would we want to give it to a Federal bureaucrat? Why would we adopt this amendment and let someone in Washington, who thinks they know better than the doctors and the local organizations as to what should be done in this sensitive area?

Defeat this amendment. Pass the bill.

Mr. LAHOOD. Mr. Chairman, I yield 3 minutes to the gentleman from Pennsylvania (Mr. KLINK).

Mr. KLINK. Mr. Chairman, I rise today in opposition of H.R. 2418 and in favor of the LaHood-Moakley amendment that goes some ways in correcting this flawed piece of legislation. If ever there were an issue that deserves to be protected from political maneuvering it is the issue of organ allocation.

This is one of the few issues that we will discuss on the floor that really means the difference between life and death. If one is waiting for an organ transplant and they do not get that transplant, it is very simple. They will die. Whether they get an organ or not that will save their life should not depend on where they live, but under the current system depending on where the organ was harvested it could be given to someone with many years to live, someone who could be pulled off of a golf course, while someone in the next town on the wrong side of a border could be lying there dying waiting for that organ.

As we know, the Department of Health and Human Services is trying to increase organ sharing; but ever since this proposed rule was announced last April, opponents have argued vigorously that the Secretary does not have the authority to set organ allocation policy because it involves a medical question, and that should best be left to those in the transplant community.

I have to tell my colleagues I am very troubled by this argument. I agree that the views of those in the transplant community should be given great weight, but I disagree with the notion that the Secretary should be forced to

turn over scientific, clinical, and medical functions of the organ procurement transplant network to a private contractor.

Leaving aside the fact that Medicare and Medicaid pay for more than 50 percent of the transplants in this country, I do not understand how an agency, which we allow to decide whether it is safe to put new drugs on the market, new devices on the market, an agency that decides what criteria NIH researchers should use, an agency that decides what procedures could be covered by Medicare now is somewhat less able to decide the qualifications dealing with how organs should be shared.

As I see it, if we give this sole discretion over such an important medical decision to a private contractor, it would really be an unconstitutional delegation of our legislative authority. What would happen if the OPTN were to suddenly change their allocation policy to give preference only to younger patients saying that people over the age of 65, for example, are too old for transplants? Or that they would decide they would prohibit the sharing of organs between people of different races?

We would agree that those things would be wrong, but under this bill the Secretary would be powerless to do anything about it.

Mr. Chairman, I think this wholesale privatization of organ sharing is a dangerous and a slippery slope. Nowhere else in society would we allow a monopoly like this to continue, let alone have the government sanction it.

People are dying because they happen to live in the wrong zip code and instead of fixing the problem with this monopoly situation on organ allocation, this bill would protect it.

□ 1345

The Moakley-LaHood amendment is a good amendment, and it corrects this flaw.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Louisiana (Mr. VITTER).

Mr. VITTER. Mr. Chairman, I rise in opposition to this amendment that reverses 16 years of legislative intent and rips decisions on organ donations from the hands of doctors and local transplant centers, placing them, instead, in the arms of Federal bureaucrats. Putting medical decisions about organ donations in the hands of doctors and transplant centers, not the Federal Government, was the intent of the law when it was created in 1984 and remains so, properly so in H.R. 2418.

In my State of Louisiana, organ and tissue donations are increasing in large part thanks to a new and innovative computerized database that shares information on donated organs with members of the medical community and their patients.

In 1999, 900 organs were donated in Louisiana, coming close to matching

the approximately 1,100 Louisianans awaiting transplants. This represents real progress. I am proud my State is helping lead the way.

But this administration's answer to the growing national shortage of organs is very different. It is not to aggressively increase organ donation but to focus, instead, energy on how a static number of organs are allocated and to do that in a way that actually increases rejection rates. This would be a terrible mistake and undercut the successful efforts of local organizations to increase donations, which is the ultimate answer.

Instead of giving bureaucrats the right to dictate organ allocation policies, we should lend our voice to increasing organ donations nationwide.

Oppose this amendment and support H.R. 2418 as it is.

Mr. LAHOOD. Mr. Chairman, how much time is remaining?

The CHAIRMAN pro tempore (Mr. EWING). The gentleman from Illinois (Mr. LAHOOD) has 13½ minutes remaining. The gentleman from Virginia (Mr. BLILEY) has 10 minutes remaining.

Mr. LAHOOD. Mr. Chairman, I am pleased to yield 2 minutes to the gentleman from Pennsylvania (Mr. COYNE).

Mr. COYNE. Mr. Chairman, I rise today in opposition to the underlying legislation, H.R. 2418, and in support of the LaHood amendment.

The system for allocating donor organs for transplant operations has long needed major reforms. The current system has failed hundreds of Americans who have died waiting for a compatible organ to become available. Waiting times across the country vary dramatically. Under the existing regime, people who are not that sick sometimes receive organs ahead of people who will die without getting the organs. This is not right.

I have been working for a number of years to get the Department of Health and Human Services to issue regulations changing the way the organs are allocated. Several years ago, Health and Human Services actually issued draft regulations that would make significant improvements in the organ allocation process. Unfortunately, a series of misguided legislative riders were attached to appropriations bills preventing HHS from issuing its final regulation for over a year.

HHS was finally allowed to issue these regulations last month, and I believe that those regulations will substantially improve the organ allocation process. Today we are considering legislation reauthorizing the National Organ Transplantation Act. We need to reauthorize this important piece of legislation.

But this bill contains a number of provisions that should not be allowed to become law. This bill would maintain existing failings in the organ allo-

cation process rather than repairing them. Enactment of this bill in its current form could hurt sick people in need of transplants.

Specifically, H.R. 2418 would not require the standardization of patient listing practices and greater allocation of organs outside the regions in which they originate. The bill also reduces the Federal Government's ability to oversee the private network which administers the organ allocation process.

Mr. Chairman, I rise in support of the LaHood amendment and in opposition to H.R. 2418.

Mr. BLILEY. Mr. Chairman, do I have the right to close?

The CHAIRMAN pro tempore. The gentleman from Virginia (Mr. BLILEY) has the right to close.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. BARRETT), a member of the Committee on Commerce.

Mr. BARRETT of Wisconsin. Mr. Chairman, I rise in opposition to this amendment. In the early days of kidney dialysis, there was a limited number of people who could benefit from kidney dialysis. So a patient in the hospital would have to go to the ethics committee of that hospital to get permission to receive it. These ethics committees became known as death squads because they would literally decide who would live or die.

Were it so easy in this debate today. Because with that problem, we solved it by saying the Federal Government would pay for dialysis. We cannot do that here because we have a limited number of organs.

Now, we can go down two roads here. We can go down the road that this amendment goes down, which says let us take this group of organs that exists right now and divide them differently. Because there are some people who are being treated fairly, some people who are being treated unfairly, so the argument goes.

If my colleagues like what UNOS is doing, they say that the Federal Government is playing God. If they do not like what UNOS is doing, they say UNOS is playing God. The fact of the matter is we are all trying to play God because we have got a limited number of organs.

But there is a danger lurking here. Under the current system, the system that the Department is trying to overturn and that this amendment is trying to overturn, the assumption is that the number of organs will remain constant. I differ with that immensely, because what this approach does is it takes away the only incentive that States have right now to procure organs. So the supply will not remain static.

If a State knows that the organs it is currently procuring under the current system are going to be shipped out of State, they are going to react like normal human beings; and they are going

to put less effort into this. So we are going down a dangerous path with this amendment.

Those proposing this amendment are arguing that the number of organs will not change, we are just distributing them differently. But the fact of the matter is we are taking away all incentives for States to come in and to procure those organs. It is a dangerous, dangerous road.

What I think it is going to do is it is going to decrease the supply of organs in this country at exactly the time we should be working to increase it.

Mr. LAHOOD. Mr. Chairman, I am pleased to yield 1 minute to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Chairman, I rise in support of the LaHood-Moakley-Rush-Peterson amendment and would urge my colleagues that, if this amendment is not adopted, to oppose the bill.

We all talk here about having a cost effective quality health care system in our country. Centers of excellence help us to achieve those results. Yet, we are allowing with the underlying bill geographical politics to affect proper medical judgment.

Without this amendment, a person who is entitled to receive an organ could be denied having that procedure at his or her choice facility. That is wrong. We should not be playing geographical politics with the lives of our constituents.

I urge my colleagues to adopt the amendment or to reject the underlying bill.

Mr. Chairman, I rise in opposition to the bill before us today.

It is a basic tenet of health care that decisions should be guided by medical necessity and quality of care.

Here in Congress, we praise centers of excellence—facilities that provide the highest quality medical care and, in doing so, attract patients from across the Nation.

We speak about the importance of allowing medical necessity determinations to be made based on the patient's condition, rather than financial consideration. In fact, this House voted overwhelmingly in support of this concept when we passed comprehensive managed care reform legislation last fall.

These are central tenets of good medicine.

H.R. 2418 violates these tenets. It locks in the current system—where geography, not the patient's medical condition, is the prime determinant for organ allocation. This is fundamentally unjust in a nation where we seek to treat all Americans equally.

We should have a national organ sharing system where, whenever possible, the sickest American receives any available organ that could save his or her life.

This bill turns life-and-death decisions over to the politics of geography. How can we play politics with the lives of critically ill patients?

Regional boundaries should be limited only by the distance that organs can be safely transported, and these boundaries should be defined so the waiting times can be minimized.

Today's limited boundaries have led to great disparities between States—with Americans in some States experiencing waiting periods as much as 10 times longer than in other States. This means that transplant patients with similar cases could wait for 5 years on one State's list or 6 months on another's. This is not a system we should defend or lock into place.

For some time now, the administration has been trying to improve the way that organs are distributed to patients across the Nation. The Department of Health and Human Services tried to issue new regulations last year. But this Congress delayed that directive from going into effect.

The Institute of Medicine, which Congress directed to study this issue in depth, affirmed the need for more active Federal oversight of the process, not less. This bill goes in the wrong direction. It reduces the Federal role in overseeing the process and delegates total authority to a private organization to establish standards governing organ transplants. That is why I oppose H.R. 2418. I urge my colleagues to vote for quality of care, for the more than 5,000 critically ill Americans who are awaiting transplants, and against this bill.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Oklahoma (Mr. ISTOOK).

Mr. ISTOOK. Mr. Chairman, I thank the gentleman from Virginia for yielding me this time.

Mr. Chairman, is it possible, should it be possible to make a life and death decision without getting the Federal Government involved? Do we have freedom, if the Federal Government says wait a minute, you cannot make these decisions, you might decide wrong, as though the Federal Government is not capable of making mistakes, as though Federal bureaucrats are the source of all wisdom and all knowledge and all pure motives and nobody else in the country possesses them?

People are trying to make very difficult decisions the best way that they can, and to do it in a way, as the gentleman from Wisconsin (Mr. BARRETT) was saying, that does the most to induce people to be organ donors.

This is going to help someone in one's community or in one's State or perhaps in one's region, and it could still end up going across the country if that is the way that it works out where the person actually is a match that qualifies best.

But to say that it all has to go through the filter of the Federal Government is saying the Federal Government does not trust everyone else in the country. It denies us freedom over life and death decisions.

People are doing the best they can with a challenging situation. By letting people try different approaches in different parts of the country, we find out what things work and what things do not work.

If my colleagues impose regimentation, uniformity imposed by Federal bureaucrats, let me tell them, any wrong mistake is a killer mistake in-

stead of finding different ways and different approaches in different parts of the country.

The Federal Government does not need to be in charge of what happens to one's body when one dies. To be told one cannot donate one's organ unless one donates it to a system where Uncle Sam has control, that is wrong. Congress should not try to claim that control. The people should not be subjected to it.

Oppose the amendment, but support the underlying bill.

Mr. LAHOOD. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania (Mr. DOYLE).

Mr. DOYLE. Mr. Chairman, I rise today in strong support of the LaHood-Rush-Moakley-Peterson amendment, and I commend the bipartisan manner in which this amendment was drafted.

This amendment includes recommendations made by the Institute of Medicine on organ allocation policies, recommendations from a study that was mandated by Congress. Mr. Chairman, this amendment is about maintaining public accountability for taxpayer funds and ensuring that medical professionals establish organ allocation policies.

I have heard arguments that, for the past 16 years, the public has been content with the present organ allocation system. How many sick patients have died on long waiting lists watching healthier and wealthier patients receive organs? Are those the individuals that do not have a problem with the present policy?

Mr. Chairman, if my colleagues' constituents want a private organization who could care less about holding themselves accountable to the public for transplant decisions, then vote for H.R. 2418. But if my colleagues' constituents want to put a public accountable organization and medical professionals in charge of such decisions, then vote for the LaHood amendment.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. GREEN), a member of the Committee on Commerce.

Mr. GREEN of Texas. Mr. Chairman, I rise in opposition to the LaHood-Moakley amendment and in support of the bill.

This amendment would create a rubber stamp National Organ Transplant Advisory Board to be selected by the Secretary to meet at her request and advise her on transplant policies with none of the independent review authority recommended by the Institute of Medicine.

The LaHood-Moakley amendment would replace today's flexible evidence-based approach to making and updating transplant policies with a statutory requirement that all organs be allocated where appropriate, in other words, the sickest-first approach that the Secretary originally advocated.

The amendment also would require by law the transplant policy to allocate all organs over the largest geographic area, a formulation that would throw out the current local, regional national approach. This requirement, together with other language in the amendment, obviously has its goal as a single national list approach.

Finally, the amendment would require by law that where transplant policies based on medical urgency are not appropriate, such as in kidney transplants, all organs be allocated among individuals based on their time on the waiting list, coupled with the requirement that waiting time differences between programs be as small as possible.

The last provision means that parts of the country that have worked hard to achieve good organ donation rates would be penalized for their success.

While I appreciate the efforts of the gentleman from Illinois (Mr. LAHOOD) and the gentleman from Massachusetts (Mr. MOAKLEY), their amendment would make matters worse for transplant centers and the medical center in Houston, Texas.

The solution is more organ donations, Mr. Chairman, not more rationing. That is what this amendment would allow us to do.

Mr. LAHOOD. Mr. Chairman, I yield 4 minutes to the gentleman from Pennsylvania (Mr. PETERSON), one of the authors of our amendment.

Mr. PETERSON of Pennsylvania. Mr. Chairman, I thank the gentleman from Illinois for yielding me the time, and I thank him for his leadership on this issue.

It is important that we focus back to what we are really talking about today, fine-tuning a system that is not perfect. If we allow the organ system to be totally independent, as many want, we will allow a total monopoly to chart its own course without any adequate oversight.

□ 1400

How many monopolies have served us well? Is the system perfect today? The recent Forbes report says the following: "Realizing that UNOS is out of control, Shalala has put out feelers for a replacement. 'I hope we have some bidders this time,' sighs Claude Fox, a physician who, as administrator of the Health Resources & Services Administration, oversees transplants. The only prospect so far is Santa Monica-based Rand. Determined to see that Rand does not walk off with a contract, UNOS' lobbyists are pushing for a law that would ensure that Graham's group will keep the contract forever; a bill that would require the organ rationing contractor to have experience, something nobody but UNOS has. It would also allow the UNOS board members to vote on the choice.'

My colleagues, do we want to give something that is as important as life

and death to a group that we have no control over if it goes wrong? We will fix it in time, but how many lives will be lost. Are doctors free to speak up today if they do not like the system? Most doctors interviewed by the Forbes report say, "most doctors involved in the business fear offending UNOS, lest their organ supply be affected."

I'm an organ donor. If I were to lose my life in an accident somewhere, and I am 50 miles from Ohio, 50 miles from New York, but I live in Pennsylvania, do I care where my organs go? I want them to go where they will save a life, where the match will be quick, where they will be handled quickly. If I was in California visiting my granddaughter and lost my life in an accident, and my organs were harvested, they would probably be used best on the West Coast not in Pennsylvania. Do we want a system that benefits people who live in the right place?

Listen to the LaHood amendment. "Shall be based on sound medical principles." Anybody disagree with that? "(B) shall be based on valid scientific data." Anybody disagree with that? "(C) shall be equitable and seek to achieve the best use of donated organs. (D) shall be designed to avoid wasting organs to avoid futile transplants to promote patient access to transplantation and to promote the efficient management of organ placement." Anybody disagree with that? "Shall be specific for each organ type or combination of organ types. Shall, where appropriate for the specific organ, provide status categories that group transplant candidates from most to least medically urgent. Medical. Shall not use patient waiting time as a criterion." We have heard that how many times today? "Unless medically appropriate. Shall be designed to share organs over as broad a geographic area as feasibly consistent." Not hard-lined rules, feasibly consistent.

This is an amendment that fine tunes the system, allows adequate oversight into the system, maximizes the saving and extension of life in America, and it does not matter where anyone lives. And it should not matter where anyone lives. If a State happens to harvest a lot, let us copy what they do and let us try to harvest a lot. But a lot has to do with demographics and the age of the population. States with older populations will not be served as well with the current system.

Each of us hopes we never need a transplant. Only my friend, the gentleman from Massachusetts (Mr. MOAKLEY), can know what that really feels like. This is a multibillion dollar business and it should not be a part of the decision-making process. We should design a system where good medicine saves the maximum number of lives with the number of organs available.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Chairman, I thank the gentleman for yielding me this time, and I rise in opposition to the LaHood amendment because it fundamentally changes the underlying bill which seeks to protect organ recipients in regional transplant centers that provide local access to life-saving organ transplantation.

We have a system that works, and it has worked well for years. I fail to see, for example, why residents of my home State of New Jersey should be forced to travel long distances to feed major transplant centers because local programs have been snuffed out. This bill would protect those residents. In my mind, feeding major transplant centers to the virtual exclusion of others is playing geographic politics. In essence, we create a funnel to certain hospitals, which create, in my mind, longer waits.

Decisions regarding organ allocations should be based on sound scientific and medical decisions. This bill seeks to do that. These decisions should be made by medical and transplant officials at the local level. This bill seeks to do that.

There is no question that we must do more to increase organ donations and make more organs available for the many Americans who need transplants, and I hope that many Americans will do what I and others have done in signing a donor card and giving of themselves. But completely uprooting the current allocation system does not address the issue of overall supply.

Let us work to increase organ donations. Let us also protect medical judgment and local programs that are saving lives. Let us vote for the underlying bill, and let us oppose the LaHood amendment.

Mr. LAHOOD. Mr. Chairman, I yield the balance of my time to the gentleman from Massachusetts (Mr. MOAKLEY) to close the debate on our side, on what I believe is a good amendment.

The gentleman has experienced a transplant, experienced organ donation, and experienced the life-saving experience of going through and receiving an organ, the ranking member of the Committee on Rules and a survivor here to tell us about it and tell us about this important amendment.

Mr. MOAKLEY. Mr. Chairman, I thank my friend and colleague, the gentleman from Illinois (Mr. LAHOOD), for his leadership on this issue; and I thank him for yielding me this time.

Mr. Chairman, I am very sorry that we must debate this matter at all, but until more Americans become organ donors, until more people tell their families they want to donate a part of themselves to others, there will be a disagreement over whether organs should go to the sickest person or to the closest person.

Mr. Chairman, I was once one of those sickest persons. As I said earlier,

5 years ago I was given 2 months to live. But a family from Virginia, who I probably will never meet, donated their son's liver and, in doing so, saved my life. And for that I will be forever grateful. But, Mr. Chairman, I am one of the lucky few. There are now 67,000 people waiting somewhere for an organ transplant, and there just are not enough organs to go around.

In response to this organ shortage, the Department of Health and Human Services has issued regulations which attempt to save as many lives as possible. Those regulations, Mr. Chairman, were established by medical professionals. They require organs to be given to the sickest patients who may benefit, rather than keep them within artificial geographic boundaries. But this bill attempts to sabotage those regulations by preventing the Department of Health and Human Services from making health care decisions that affect thousands upon thousands of people.

This bill gives a private contractor authority over billions and billions of dollars of Medicare and Medicaid money, not to mention people's lives. This is all done without one scintilla of regulation. This private contractor, embodied with God-like powers over who lives, over who dies, powers over which transplant centers stay open and which transplant centers close, is an agency which will answer to no one but itself.

This amendment allows the Department of Health and Human Services to continue its oversight on this issue. This amendment simply requires a small measure of public accountability and oversight in a process that means life or death for thousands upon thousands of Americans.

Mr. Chairman, what this bill really does is it takes the public voice out of the public health. The LaHood-Rush-Peterson-Moakley amendment puts it back in. Where an individual lives should not determine how they live or if they live or if they die.

Mr. BLILEY. Mr. Chairman, I yield myself the balance of my time.

First of all, Mr. Chairman, let me say this. There has been a lot of discussion about the fact that the Secretary has no authority.

The Secretary has oversight authority. The Secretary can abrogate the contract. Indeed, UNOS' contract has been renewed several times. They brought in Rand Corporation. Rand withdrew. UNOS has done a fine job and is doing a fine job.

To my good friend from Massachusetts, who got his life-saving transplant at the University of Virginia Medical Center in Charlottesville, under this amendment that transplant center may not exist any more because it will not be in a big population center. So it could very well not be available for some future transplant.

This is a bad amendment, and I urge its rejection.

Mrs. MALONEY of New York. Mr. Chairman, I rise in support of the LaHood Amendment to H.R. 2418, The Organ Procurement and Transplantation Network Amendments of 1999.

This amendment keeps critical public health decisions where they belong—under the purview of The Department of Health and Human Services.

Instead of turning these decisions over to a private organization holding less accountability and substantial financial stakes in how the organ-allocation system operates.

The decisions that the base bill, H.R. 2418 would transfer to a private organ network are too important to go unchecked.

They are unquestionably life and death decisions.

New organ-allocation regulations proposed by the Administration and three times delayed by Congressionally mandated moratoriums, were developed by Secretary Shalala and leading experts in the field of organ transplantation.

And they are supported by an Institute of Medicine study completed last July.

But H.R. 2418 would throw out the Secretary's regulations which make the organ-allocation system fairer.

The revised regulations get organs to patients based on medical need, as opposed to geography and politics, and the financial interests of individuals.

Furthermore, H.R. 2418 ignores scientific evidence calling for new regulations in favor of maintaining an outdated and inefficient system which serves business, and political interests instead of public health and patient needs.

Already more than two years of a more equitable and efficient system has been lost to political maneuvering over this issue.

In November of last year, The Washington Post published a cogent op-ed titled "Organs Held Hostage" which reprimanded this Congress for doing just that—keeping life-saving organs from getting to the sickest patients, in the most timely manner, and perpetuating an unfair and inefficient system which favors wealthier patients who can get on multiple waiting lists and fly to wherever a needed organ becomes available.

Isn't it time we allowed the world-class doctors and transplant centers that we take so much pride in, to get on with the saving of lives?

I urge my colleagues to vote for the LaHood Amendment.

Mr. BLILEY. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN pro tempore (Mr. EWING). All time has expired.

The question is on the amendment offered by the gentleman from Illinois (Mr. LAHOOD).

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

RECORDED VOTE

Mr. LAHOOD. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The CHAIRMAN pro tempore. This will be a 15-minute vote on the LaHood

amendment, followed by two 5-minute votes on the amendments for which demands for recorded votes were postponed earlier today in the following order:

Amendment No. 1 offered by the gentlewoman from Colorado (Ms. DEGETTE); and amendment No. 2 offered by the gentleman from Minnesota (Mr. LUTHER).

The vote was taken by electronic device, and there were—ayes 160, noes 260, answered "present" 1, not voting 13, as follows:

[Roll No. 98]

AYES—160

Ackerman	Goodling	Olver
Baca	Gutierrez	Owens
Barrett (NE)	Hall (OH)	Payne
Bartlett	Hinchev	Pelosi
Becerra	Hoefel	Peterson (PA)
Bereuter	Holden	Phelps
Berman	Horn	Pomeroy
Biggert	Houghton	Porter
Blagojevich	Hoyer	Price (NC)
Boehler	Hunter	Quinn
Bonior	Hyde	Radanovich
Bono	Jackson (IL)	Rahall
Borski	Johnson, E. B.	Rangel
Brown (OH)	Jones (OH)	Regula
Capps	Kanjorski	Rodriguez
Capuano	Kennedy	Roybal-Allard
Cardin	Kildee	Rush
Carson	King (NY)	Sabo
Castle	Klink	Sanchez
Clay	Kucinich	Sanders
Clayton	LaFalce	Sawyer
Condit	LaHood	Schakowsky
Conyers	Lantos	Serrano
Costello	Larson	Sessions
Coyne	Lee	Sherman
Crowley	Levin	Sherwood
Cummings	Lipinski	Shimkus
Davis (IL)	Lofgren	Slaughter
DeGette	Lowey	Smith (WA)
Delahunt	Luther	Stabenow
DeLauro	Maloney (CT)	Stark
Dicks	Maloney (NY)	Stenholm
Dingell	Markey	Strickland
Dixon	Mascara	Stupak
Doggett	Matsui	Tauscher
Dooley	McCarthy (MO)	Thompson (CA)
Doyle	McCarthy (NY)	Thompson (MS)
Dreier	McDermott	Tierney
Ehrlich	McGovern	Toomey
Engel	McIntyre	Towns
English	McNulty	Udall (CO)
Eshoo	Meehan	Udall (NM)
Etheridge	Meeks (NY)	Velazquez
Evans	Millender-	Visclosky
Ewing	McDonald	Waters
Farr	Miller, George	Watt (NC)
Filner	Moakley	Waxman
Forbes	Mollohan	Weiner
Frank (MA)	Morella	Weldon (PA)
Frost	Murtha	Weller
Gejdenson	Nadler	Weygand
Gekas	Napolitano	Woolsey
Gephardt	Neal	Wynn
Gilchrest	Oberstar	

NOES—260

Abercrombie	Bentsen	Burton
Aderholt	Berkley	Buyer
Allen	Berry	Callahan
Andrews	Bilbray	Calvert
Archer	Bilirakis	Camp
Armye	Bishop	Canady
Bachus	Bliley	Cannon
Baird	Blumenauer	Chabot
Baker	Blunt	Chambliss
Baldacci	Boehner	Chenoweth-Hage
Baldwin	Bonilla	Clement
Ballenger	Boswell	Clyburn
Barcia	Boucher	Coble
Barr	Boyd	Coburn
Barrett (WI)	Brady (TX)	Collins
Barton	Brown (FL)	Combest
Bass	Bryant	Cooksey
Bateman	Burr	Cox

Cramer	Johnson (CT)	Riley
Cubin	Johnson, Sam	Rivers
Cunningham	Jones (NC)	Roemer
Danner	Kasich	Rogan
Davis (FL)	Kelly	Rogers
Davis (VA)	Kilpatrick	Rohrabacher
Deal	Kind (WI)	Ros-Lehtinen
DeFazio	Kingston	Rothman
DeLay	Kleczka	Royce
DeMint	Knollenberg	Ryan (WI)
Deutsch	Kolbe	Ryun (KS)
Dickey	Kuykendall	Salmon
Doolittle	Lampson	Sandlin
Duncan	Largent	Sanford
Dunn	Latham	Saxton
Edwards	LaTourette	Scarborough
Ehlers	Lazio	Schaffer
Emerson	Leach	Scott
Everett	Lewis (CA)	Sensenbrenner
Fletcher	Lewis (GA)	Shadegg
Foley	Lewis (KY)	Shaw
Ford	Linder	Shays
Fossella	LoBiondo	Shows
Fowler	Lucas (KY)	Simpson
Franks (NJ)	Lucas (OK)	Siskisky
Frelinghuysen	Manzullo	Skeen
Gallegly	McCollum	Skelton
Ganske	McCrery	Smith (MI)
Gibbons	McHugh	Smith (NJ)
Gillmor	McInnis	Smith (TX)
Gilman	McIntosh	Snyder
Gonzalez	McKeon	Souder
Goode	McKinney	Spence
Goodlatte	Meek (FL)	Spratt
Gordon	Menendez	Stearns
Goss	Metcalfe	Stump
Graham	Mica	Sununu
Granger	Miller (FL)	Sweeney
Green (TX)	Miller, Gary	Talent
Green (WI)	Minge	Tancred
Gutknecht	Mink	Tanner
Hall (TX)	Moore	Tauzin
Hansen	Moran (KS)	Taylor (MS)
Hastings (FL)	Moran (VA)	Taylor (NC)
Hastings (WA)	Nethercutt	Terry
Hayes	Ney	Thomas
Hayworth	Norwood	Thornberry
Hefley	Nussle	Thune
Herger	Obey	Thurman
Hill (IN)	Ortiz	Tiahrt
Hill (MT)	Ose	Trafficant
Hilleary	Oxley	Turner
Hilliard	Packard	Upton
Hinojosa	Pallone	Vitter
Hobson	Pascrell	Walden
Hoekstra	Pastor	Walsh
Holt	Paul	Wamp
Hooley	Pease	Watkins
Hostettler	Peterson (MN)	Watts (OK)
Hulshof	Petri	Weldon (FL)
Hutchinson	Pickering	Wexler
Inslie	Pickett	Whitfield
Isakson	Pitts	Wicker
Istook	Pombo	Wilson
Jackson-Lee	Portman	Wise
(TX)	Pryce (OH)	Wolf
Jefferson	Ramstad	Wu
Jenkins	Reyes	Young (AK)
John	Reynolds	Young (FL)

ANSWERED "PRESENT"—1

Kaptur

NOT VOTING—13

Brady (PA)	Fattah	Roukema
Campbell	Greenwood	Shuster
Cook	Martinez	Vento
Crane	Myrick	
Diaz-Balart	Northup	

□ 1433

Messrs. WALDEN of Oregon, Mrs. CUBIN, and Messrs. FRELINGHUYSEN and BISHOP changed their vote from "aye" to "no."

Mr. BLAGOJEVICH, Ms. WOOLSEY, and Mr. MEEKS of New York changed their vote from "no" to "aye."

So the amendment was rejected.

The result of the vote was announced as above recorded.

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (Mr. EWING). Pursuant to House Resolution 454, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device will be taken on each amendment on which the Chair has postponed further proceedings.

AMENDMENT NO. 1 OFFERED BY MS. DEGETTE

The CHAIRMAN pro tempore. The pending business is the demand for a recorded vote on Amendment No. 1 offered by the gentlewoman from Colorado (Ms. DEGETTE) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The CHAIRMAN pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 420, noes 0, not voting 14, as follows:

[Roll No. 99]

AYES—420

Abercrombie	Calvert	Duncan
Ackerman	Camp	Dunn
Aderholt	Canady	Edwards
Allen	Cannon	Ehlers
Andrews	Capps	Ehrlich
Archer	Capuano	Emerson
Army	Cardin	Engel
Baca	Carson	English
Bachus	Castle	Eshoo
Baird	Chabot	Etheridge
Baker	Chambliss	Evans
Baldacci	Chenoweth-Hage	Everett
Baldwin	Clay	Ewing
Ballenger	Clayton	Farr
Barcia	Clement	Filner
Barr	Clyburn	Fletcher
Barrett (NE)	Coble	Foley
Barrett (WI)	Coburn	Forbes
Bartlett	Collins	Ford
Barton	Combust	Fossella
Bass	Condit	Fowler
Bateman	Conyers	Frank (MA)
Becerra	Cooksey	Franks (NJ)
Bentsen	Costello	Frelinghuysen
Bereuter	Cox	Frost
Berkley	Coyne	Galleghy
Berman	Cramer	Ganske
Berry	Crowley	Gejdenson
Biggert	Cubin	Gekas
Bilbray	Cummings	Gephardt
Bilirakis	Cunningham	Gibbons
Bishop	Danner	Gilchrest
Blagojevich	Davis (FL)	Gillmor
Blumenauer	Davis (IL)	Gilman
Blunt	Davis (VA)	Gonzalez
Boehlert	Deal	Goode
Boehner	DeFazio	Goodlatte
Bonilla	DeGette	Goodling
Bonior	Delahunt	Gordon
Bono	DeLauro	Goss
Borski	DeLay	Graham
Boswell	DeMint	Granger
Boucher	Deutsch	Green (TX)
Boyd	Dickey	Green (WI)
Brady (TX)	Dicks	Gutierrez
Brown (FL)	Dingell	Gutknecht
Brown (OH)	Dixon	Hall (OH)
Bryant	Doggett	Hall (TX)
Burr	Dooley	Hansen
Burton	Doolittle	Hastings (FL)
Buyer	Doyle	Hastings (WA)
Callahan	Dreier	Hayes

Hayworth	McInnis	Sawyer
Hefley	McIntosh	Saxton
Herger	McIntyre	Scarborough
Hill (IN)	McKeon	Schaffer
Hill (MT)	McKinney	Schakowsky
Hilleary	McNulty	Scott
Hilliard	Meehan	Sensenbrenner
Hinchey	Meek (FL)	Serrano
Hinojosa	Meeks (NY)	Sessions
Hobson	Menendez	Shadegg
Hoeffel	Metcalfe	Shaw
Hoekstra	Mica	Shays
Holden	Millender-	Sherman
Holt	McDonald	Sherwood
Hooley	Miller (FL)	Shimkus
Horn	Miller, Gary	Shows
Hostettler	Miller, George	Simpson
Houghton	Minge	Sisisky
Hoyer	Mink	Skeen
Hulshof	Moakley	Skelton
Hunter	Mollohan	Slaughter
Hutchinson	Moore	Smith (MI)
Hyde	Moran (KS)	Smith (NJ)
Inslee	Moran (VA)	Smith (TX)
Isakson	Morella	Smith (WA)
Istook	Murtha	Snyder
Jackson (IL)	Nadler	Souder
Jackson-Lee	Napolitano	Spence
(TX)	Neal	Spratt
Jefferson	Nethercutt	Stabenow
Jenkins	Ney	Stark
John	Norwood	Stearns
Johnson (CT)	Nussle	Stenholm
Johnson, E. B.	Oberstar	Strickland
Johnson, Sam	Obey	Stump
Jones (NC)	Olver	Stupak
Jones (OH)	Ortiz	Sununu
Kanjorski	Ose	Sweeney
Kaptur	Owens	Talent
Kasich	Oxley	Tancredo
Kelly	Packard	Tanner
Kennedy	Pallone	Tauscher
Kildee	Pascrell	Tauzin
Kilpatrick	Pastor	Taylor (MS)
Kind (WI)	Paul	Taylor (NC)
King (NY)	Payne	Terry
Kingston	Pease	Thomas
Klecзка	Peterson (MN)	Thompson (CA)
Klink	Peterson (PA)	Thompson (MS)
Knollenberg	Petri	Thornberry
Koibe	Phelps	Thune
Kucinich	Pickering	Thurman
Kuykendall	Pickett	Tiahrt
LaFalce	Pitts	Tierney
LaHood	Pombo	Toomey
Lampson	Pomeroy	Towns
Lantos	Porter	Traficant
Largent	Portman	Turner
Larson	Price (NC)	Udall (CO)
Latham	Pryce (OH)	Udall (NM)
LaTourrette	Quinn	Upton
Lazio	Radanovich	Velazquez
Leach	Rahall	Visclosky
Lee	Ramstad	Vitter
Levin	Rangel	Walden
Lewis (CA)	Regula	Walsh
Lewis (GA)	Reyes	Wamp
Lewis (KY)	Reynolds	Waters
Linder	Riley	Watkins
Lipinski	Rivers	Watt (NC)
LoBiondo	Rodriguez	Watts (OK)
Lofgren	Roemer	Waxman
Lowey	Rogan	Weiner
Lucas (KY)	Rogers	Weird
Lucas (OK)	Rohrabacher	Weldon (FL)
Luther	Ros-Lehtinen	Weldon (PA)
Maloney (CT)	Rothman	Weller
Maloney (NY)	Roukema	Wexler
Manzullo	Roybal-Allard	Weygand
Markey	Royce	Whitfield
Mascara	Rush	Wicker
Matsui	Ryan (WI)	Wilson
Goss	Ryan (KS)	Doyle
McCarthy (MO)	Sabo	Wise
McCarthy (NY)	Salmon	Wolf
McCormack	Sanchez	Woolsey
McCrery	Sanders	Wu
McDermott	Sandlin	Wynn
McGovern	Sanford	Young (AK)
McHugh		Young (FL)

NOT VOTING—14

Bliley	Cook	Fattah
Brady (PA)	Crane	Greenwood
Campbell	Diaz-Balart	

Martinez	Northup	Shuster
Myrick	Pelosi	Vento

□ 1442

Mr. NORWOOD changed his vote from “no” to “aye.”

So the amendment was agreed to.

The result of the vote was announced as above recorded.

Stated for:

Mr. BLILEY. Mr. Chairman, on rollcall No. 99 I was inadvertently detained. Had I been present, I would have voted “yes.”

AMENDMENT NO. 2 OFFERED BY MR. LUTHER

The CHAIRMAN pro tempore. The pending business is the demand for a recorded vote on Amendment No. 2 offered by the gentleman from Minnesota (Mr. LUTHER) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The Clerk redesignated the amendment.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The CHAIRMAN pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 137, noes 284, not voting 13, as follows:

[Roll No. 100]

AYES—137

Ackerman	Gephardt	Oberstar
Allen	Gilchrest	Olver
Baldacci	Goodling	Owens
Barrett (NE)	Gutierrez	Payne
Becerra	Hinchey	Pelosi
Bereuter	Hoeffel	Peterson (PA)
Berman	Holden	Phelps
Biggert	Hoyer	Pomeroy
Blagojevich	Inslee	Porter
Blumenauer	Jackson (IL)	Price (NC)
Boehlert	Johnson (CT)	Quinn
Bonior	Johnson, E.B.	Rahall
Borski	Jones (OH)	Rangel
Brown (OH)	Kanjorski	Roybal-Allard
Capps	Kennedy	Rush
Capuano	Kildee	Sabo
Cardin	Klink	Sanchez
Carson	LaHood	Sanders
Castle	Lantos	Sawyer
Clay	Larson	Schakowsky
Clayton	Lee	Serrano
Costello	Levin	Sessions
Coyne	Lipinski	Shays
Crowley	Lofgren	Sherman
Cummings	Lowey	Sherwood
Davis (IL)	Luther	Slaughter
DeGette	Maloney (CT)	Snyder
Delahunt	Markey	Stabenow
DeLauro	Mascara	Stark
Dicks	Matsui	Strickland
Dingell	McCarthy (MO)	Stupak
Dixon	McIntyre	Terry
Dooley	McNulty	Thompson (CA)
Doyle	Meehan	Tierney
Dreier	Meeks (NY)	Toomey
Engel	Millender-	Towns
English	McDonald	Udall (CO)
Eshoo	Miller, George	Visclosky
Etheridge	Minge	Walden
Evans	Moakley	Waters
Farr	Mollohan	Waxman
Filner	Morella	Weiner
Forbes	Murtha	Weygand
Frank (MA)	Nadler	Wise
Gejdenson	Napolitano	Woolsey
Gekas	Neal	Wynn

NOES—284

Abercrombie Gordon
Aderholt Goss
Andrews Graham
Archer Granger
Armey Green (TX)
Baca Green (WI)
Bachus Gutknecht
Baird Hall (OH)
Baker Hall (TX)
Baldwin Hansen
Ballenger Hastings (FL)
Barcia Hastings (WA)
Barr Hayes
Barrett (WI) Hayworth
Bartlett Hefley
Barton Herger
Bass Hill (IN)
Bateman Hill (MT)
Bentsen Hilleary
Berkley Hilliard
Berry Hinojosa
Bilbray Hobson
Bilirakis Hoekstra
Bishop Holt
Bliley Hooley
Blunt Horn
Boehner Hostettler
Bonilla Houghton
Bono Hulshof
Boswell Hunter
Boucher Hutchinson
Boyd Hyde
Brady (TX) Isakson
Brown (FL) Istook
Bryant Jackson-Lee
Burr (TX)
Burton Jefferson
Buyer Jenkins
Callahan John
Calvert Johnson, Sam
Camp Jones (NC)
Canady Kaptur
Cannon Kasich
Chabot Kelly
Chambliss Kilpatrick
Chenoweth-Hage Kind (WI)
Clement King (NY)
Clyburn Kingston
Coble Kleczka
Coburn Knollenberg
Collins Kolbe
Combest Kucinich
Condit Kuykendall
Conyers LaFalce
Cooksey Lampson
Cox Largent
Cramer Latham
Cubin LaTourette
Cunningham Lazio
Danner Leach
Davis (FL) Lewis (CA)
Davis (VA) Lewis (GA)
Deal Lewis (KY)
DeFazio Linder
DeLay LoBiondo
DeMint Lucas (KY)
Deutsch Lucas (OK)
Dickey Maloney (NY)
Doggett Manzullo
Doolittle McCarthy (NY)
Duncan McCollum
Dunn McCreery
Edwards McDermott
Ehlers McGovern
Ehrlich McHugh
Emerson McLinnis
Everett McIntosh
Ewing McKeon
Fletcher McKinney
Foley Meek (FL)
Ford Menendez
Fossella Metcalf
Fowler Mica
Franks (NJ) Miller (FL)
Frelinghuysen Miller, Gary
Frost Mink
Gallegly Moore
Ganske Moran (KS)
Gibbons Moran (VA)
Gillmor Nethercutt
Gihlan Ney
Gonzalez Norwood
Goode Obey
Goodlatte Ortiz

Wicker
Wilson
Wolf
Wu
Young (AK)
Young (FL)

NOT VOTING—13

Brady (PA) Fattah
Campbell Greenwood
Cook Martinez
Crane Myrick
Diaz-Balart Northrup

□ 1450

So the amendment was rejected.
The result of the vote was announced
as above recorded.

PERSONAL EXPLANATION

Mrs. NORTHROP. Mr. Chairman, I was unavoidably detained and unable to record a vote by electronic device on the LaHood amendment to H.R. 2418. However, had I been present, I would have voted "no."

I was unable to cast a vote on the DeGette amendment to H.R. 2418. Had I been present, I would have voted "aye."

I was unable to cast a vote on the Luther amendment to H.R. 2418. Had I been present, I would have voted "no."

The CHAIRMAN pro tempore (Mr. EWING). It is now in order to consider Amendment No. 4 printed in House report 106-557.

AMENDMENT NO. 4 OFFERED BY MR. BARRETT OF WISCONSIN

Mr. BARRETT of Wisconsin. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. BARRETT of Wisconsin:

Page 28, after line 3, insert the following subsection (and redesignate subsequent subsections accordingly):

“(c) GRANTS TO STATES.—The Secretary may make grants to States for the purpose of assisting States in carrying out organ donor awareness, public education and outreach activities and programs designed to increase the number of organ donors within the State, including living donors. To be eligible, each State shall—

“(1) submit an application to the Department in the form prescribed;

“(2) establish yearly benchmarks for improvement in organ donation rates in the State;

“(3) develop, enhance or expand a State donor registry, which shall be available to hospitals, organ procurement organizations, and other States upon a search requests; and

“(4) report to the Secretary on an annual basis a description and assessment of the State’s use of these grant funds, accompanied by an assessment of initiatives for potential replication in other States.

Funds may be used by the State or in partnership with other public agencies or private sector institutions for education and awareness efforts, information dissemination, activities pertaining to the State organ donor registry, and other innovative donation specific initiatives, including living donation.

Page 28, line 12, strike “\$10,000,000” and insert “\$15,000,000”.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, the gentleman from Wisconsin (Mr. BARRETT) and a Member opposed each will control 10 minutes.

Mr. BLILEY. Mr. Chairman, I rise to claim the time in opposition, although I am not in opposition.

The CHAIRMAN pro tempore. Without objection, the gentleman from Virginia (Mr. BLILEY) will control the time in opposition.

There was no objection.

The CHAIRMAN pro tempore. The Chair recognizes the gentleman from Wisconsin (Mr. BARRETT).

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, this amendment provides a direct mechanism to foster State organ donor awareness, public education and outreach activities and programs designed to increase the number of organ donors within the State, including living donors. Stated simply, the amendment provides a financial incentive for States to tackle creatively the challenges inherent in organ donation awareness and education.

States can play a pivotal role in organ donation success, despite the huge geographic variations and differences across State lines. This amendment authorizes direct grants to States and allows partnerships with other public agencies or private sector institutions within States to mutually undertake organ donation activity.

Under this amendment, States must submit applications in the form prescribed by the Secretary of Health and Human Services and shall establish yearly benchmarks for improvements in organ donation rates in the States. States would be required annually to provide a report to the Secretary, including a description and assessment of the State’s use of grant funds and identification of initiatives for potential replication in other States.

Mr. Chairman, this amendment correctly recognizes that States need flexibility designed to address their own organ donation priority areas of concern, yet provides the necessary challenge and financial incentives to address the underlying reason for the organ allocation program in America today, namely, the scarcity of donated organs.

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

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

I rise in support of the amendment offered by the gentleman from Wisconsin (Mr. BARRETT) and the gentleman from Wisconsin (Mr. KLECZKA).

This amendment would provide financial incentives for States to creatively tackle the challenges inherent in organ donation awareness and education. It would also authorize direct grants to States to allow partnerships with other public agencies or private sector institutions within States to mutually undertake organ donation activities.

As I have said many times before, Americans who donate their organs, tissue, bone marrow or blood to save

another's life are heroes. But, despite the generosity of the American people and improvements in medical treatments for transplant patients, the supply of organs continues to be tragically short of the need for transplantation among patients with in-stage organ disease and organ failure.

Every year, the number of patients who die while waiting for a transplant increases, as does the national waiting list, which now exceeds 65,000 patients waiting for various organ transplants. We must do more.

As many know, the Committee on Commerce has spent a great deal of time and effort in the last year working to develop good solutions to the difficult problem of increasing the supply of donated organs while safeguarding the system from unintended bureaucratic interference that would dramatically harm efforts to increase donations. Many of these ideas are embodied in H.R. 2418. I believe this amendment will strengthen our public education campaign with respect to organ donation and ultimately increase the amount of organs, tissue, bone marrow, or blood in our transplant centers. Organ donation and awareness is half the battle, and I applaud the gentleman from Wisconsin for tackling the inherent challenges in organ donation activities.

Mr. Chairman, I urge my colleagues to support this amendment.

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

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield 1½ minutes to the gentleman from Indiana (Mr. ROEMER).

Mr. ROEMER. Mr. Chairman, I rise in strong support of this amendment on education, information, and inspiration.

There is a true story about a family, Reg and Maggie Green, who took their young sons to Italy on vacation, and one of them, Nicholas, was tragically killed in a shooting on the highway, on the super highway. This couple, instead of sprinting, leaving out of Italy, decided to donate seven of Nicholas' organs to citizens of Italy. In the first few days after Nicholas' death, the number of people signing organ donor cards in Italy quadrupled, quadrupled; and donations there last year were more than double the rate that they were in the year before he died.

Mr. Chairman, this is an inspirational story about Nicholas Green, his family, and now the "Nicholas Effect." When we can get these kinds of stories shared, a foundation started, the Nicholas Green Foundation, more people aware of the importance of organs and organ donation programs, sharing of inspiration, sharing of these true stories, we will help address this program and this problem.

So no matter where one is on the question of medical necessity versus location or geography, support this

good amendment and support efforts to get information, education, and inspirational stories out there.

Mr. Chairman, I include the following for the RECORD:

Warm, moving, and uplifting . . . a father's story of how a boy's life helped save thousands.

Reg Green knows sorrow. He also knows, first-hand, of people around the world who have risen to the challenge of tragedy with acts of compassion and greatness. Here is the intimate story (behind the headlines and talk shows) of the Greens' fateful trip to Italy: how a botched robbery changed their lives and how Reg and Maggie's private decision to donate their son's organs thrust them into the world spotlight.

The world's response to the Greens' personal tragedy is called the Nicholas effect. No matter their nationality or calling, people respond from the heart—presidents, movie stars, schoolchildren, grandmothers, Boy scouts, soccer players, surgeons, and organ recipients. Organ donor cards are signed. Poems are written, pictures painted, parks dedicated, scholarships established, medals given, children hugged.

The effect continues today, stronger than anyone could have predicted. More than a tale of loss, this is a testament to the power of healing and love.

AN INTERVIEW WITH REG GREEN

(By Doug Hill)

Reg Green is a British-born financial writer who lives in Bodega Bay, California. On the night of September 29, 1994, he was on vacation in southern Italy with his wife and two children when highway robbers shot out the windows of their rented car. Nicholas Green, age 7, asleep in the back seat, was hit in the head. Two days later, he was declared brain dead, and the parents agreed to donate his organs for transplant. Nicholas' heart, kidneys, corneas, liver and pancreas cells transformed the lives of seven Italians while the Greens' generosity and spirit inspired the world.

Since then, Reg Green, 70, and Maggie Green, 37, have become international leaders in the movement to promote organ donations, while the power of what is called "the Nicholas effect" continues to move anyone who hears their story. They live with their daughter Eleanor, 9, and twins, Martin and Laura who will be 3 in May.

Reg Green has just completed a book which describes the Greens' incredible journey in exquisite and often painful detail. "The Nicholas Effect" is to be published by O'Reilly & Associates in April. Recently, Green took time out to discuss "The Nicholas Effect" with interviewer Doug Hill.

Hill: What is the Nicholas Effect?

Green: The Nicholas Effect started out by being a very big increase in people in Italy signing their donor cards. Within a few days of Nicholas' death, those signings quadrupled. That was the initial response, and that took our breath away at the time, but I was determined, as Maggie was, that this shouldn't be just a transient thing. We both had this feeling that this could turn out to be one of those things that people would look back on sadly when they remembered it, but would have no real effect on their actions. Some other tragedy would come along that would supersede this one. So we wanted to try to make sure that whatever effect there was would be more lasting. Therefore, we did everything we could to etch it into people's minds. We contacted the media and we gave all the interviews that anybody asked for—

we've hardly ever turned down a request for an interview. We made two videos, we've written articles, we dressed up as Santa Claus for an Italian magazine. The main thrust of all this was to remind people of the terrible loss of life around the world because of the low rate of organ donation. There were subsidiary things, however, which we began to see as we got into it. People were being brought closer together by this story. I imagined parents all over the world giving their children an extra hug before they went off to school in the morning or reading an extra page to them at bedtime. So we wanted that to continue as well.

Hill: You've said that the Nicholas Effect is about "life coming bravely out of death." Is that the idea?

Green: Yes. Absolutely.

Hill: That message runs counter to a lot of the cynicism we encounter today, doesn't it?

Green: Yes. I think one of the wonderful things about the Nicholas Effect is that it has uncovered this sense of togetherness—what the Italians call "solidarity"—that exists between people, people who are often complete strangers. Obviously that's true with organ donation, where you've no idea where the organs are going. White men are walking around with black women's hearts, Anglos are breathing with Mexican lungs, and American children are alive because of donations made by foreign parents—and vice-versa. Human parts are interchangeable. I think that's a wonderful lesson. The differences between us are trifling compared to what we have in common.

Hill: I was struck when reading the book how many times you met someone and then found out quite a bit later that they had experienced some sort of tragedy in their own lives.

Green: Yes, that struck me too, very forcibly. Both in the case of strangers or people I've known for a long time about whom I never suspected anything of that sort. But somehow the barriers come down and they tell us these stories. Just the other day I went into the grocery store and went to the butcher counter. The lady who served me said, "By the way, you're the father, aren't you?" I said yes, and she said, "We had a similar incident," and she proceeded to tell me about a personal tragedy. I've seen that woman a lot of times and that never emerged. She was just the woman who was serving the sausage. Now behind that is the real person.

Hill: How much of the Nicholas Effect has to do with the special qualities of Nicholas himself?

Green: I've often asked myself that. I think quite a lot. I know, of course, that it was our decision to donate the organs, that he wasn't old enough to know what that meant, but somehow with Nicholas you wanted to be your very best. He was a very good little boy and he made you want to live up to his expectations. He stamped his personality on this story. Time and again when reporters would come here, somehow they've been captured by his personality. So the effect was shared according to his own character.

Hill: I must say that as a father I sometimes felt jealous of the bond that you seemed to have with him.

Green: Well, we were very close. I'm quite old, you know, to be the father of a young child. That may have something to do with it. It may be when you're a younger father you've got your own career to worry about, you're very busy, you haven't settled down yet. I work from home, so that helped, also. But, yes, we were very close.

Hill: You describe yourself as an agnostic. Still, do you see a spiritual quality to the Nicholas Effect of any sort?

Green: No, I don't, really, not in any conventional sense. I still don't believe in an afterlife, for example. I've never been tempted to believe in it. It would be nice in a way to think that was true now, but I've never been comfortable with the idea and I've never dabbled at it since Nicholas died. I've always taken hope from the idea that there's a lot you can do here in the world, and that what you do here can be about love rather than hate—kindness rather than cruelty. So my solace comes from what can happen on earth, and I see so much good coming out of all this. Nicholas' example has helped save literally thousands of lives in Italy alone, because the organ donation rates have more than doubled. So that's part of it. The other part of it is that other thing we've been talking about, the sense of people feeling closer together than they did before.

Hill: Was the book difficult for you to write?

Green: I had tears in my eyes many times while I was writing it and some of it was wrenching, going back over Nicholas' death, for example, having to recreate that. But, for the most part, the loss of Nicholas has been so great that talking about it really doesn't make it worse. It was also nice to be able to put down on paper the happier times I remember too.

Hill: What do you hope to accomplish with the book?

Green: Again, there's the two levels of things. On the practical level, I'm hoping it will be another of the building blocks by which organ donation becomes not unusual or horrifying, but the natural thing to do, as natural as putting on a seat belt. And I think it can become as natural as that. There's no organized opposition to organ donation. Whenever they take a poll, eighty percent or more of the people in this country say they are in favor of it and would do it. They don't do it, but not because there's a principled objection to it, but because of circumstances. I think people can be overwhelmed when there is a sudden death. So what I'm hoping to do on that front is make them aware of the importance of it—of the consequences of a refusal. When people are asked to do it, they tend to think of that child or husband of theirs and the organs being taken away from them, and they're frightened or worried by it. I want them to see the other side. If you don't do it, this is what somebody else has to suffer. Somebody else has to go through what you're going through if you don't make that decision. On the organ donation level, that's it. I also wanted to show the sense of solidarity between quite different kinds of people that this incident has produced.

Hill: What specific steps should people take to make sure that their organs will be available for transplant?

Green: The most important is to discuss it with your family so that if there is a brain death in the family, their minds are already attuned to this and it doesn't take them by surprise. There's a new initiative started by the American Society of Transplant Surgeons, and what they ask you to do, instead of signing the donor card, is to just sit down with the family and say, "Look, if anything were to happen, I'd want you to give my organs and tissues." The others in the family who agreed would sign a document, the Family Pledge, and then they'd probably put it away and forget where it was and that would be the end of it. It would have no legal standing, but it would mean that when death did

occur, perhaps sooner than anyone expected, that conversation, that joint decision, would come to mind. It wouldn't work every time, but we think in many cases it would have the right effect—people would say, "Yes, that's just what he wanted."

Hill: I was struck by your comment in the book that transplantation means we're "no longer at the mercy of arbitrariness. We have a say in the outcome." Could you elaborate on that?

Green: I connect it with the idea that death has a purpose. Death is not simply some terrible thing that happens. None of us is going to like it, but it's there for a reason: the old and the feeble have to be replaced by younger and stronger ones. But people die every day because of the failure of one organ. Many of them are young, some only babies. People with whole lives in front of them are suddenly dead. Transplantation means that we can step in and save such people.

Hill: Did you have any thoughts about donation before your experience with Nicholas?

Green: Not really. I had been very impressed by Christiaan Barnard's early experiments with heart transplants, which seemed like going to the moon. But apart from that, no. I can't recall any conversation that Maggie and I had beforehand. She, it runs out, had signed a donor card and I hadn't.

Hill: So you were pretty much like most of us.

Green: Yes, that's right. It was a revelation to me how much could be achieved. I think in our cases, either one of us would have done it for the other, because it would have been so obvious to us, just as it was in Nicholas' case. And I think many families are like that—they know each other well and would know enough to go ahead and do it, without prior agreement. But still, it's very valuable to have had a discussion, particularly for bigger families, where one person objecting can stop the whole process. This thing has to be done quite promptly—you've only got a short time to make the decision. You may be able to get in touch with your husband, for instance, but suppose you can't get hold of your mother, or his mother? That's what often happens. People take the safe course because it's too difficult to contact everybody, and they're afraid that somebody might object.

Hill: You often describe the decision to donate Nicholas' organs as "obvious" or "easy." I think many readers may find that hard to understand—I know I did. Why would it have been that obvious?

Green: It was obvious simply because Nicholas was dead. There was no question in our minds that he wasn't in a coma, for example. Those organs were of no use to him anymore. Not only did Nicholas not need those organs anymore, but the essential Nicholas was clearly not in that body. Whether it was a soul or our memories of him, or the legacy he left behind—that was where Nicholas was. In no way conceivable to us could we be hurting him by using his body, and yet we could be using it to help other people. On top of that, we know that it was a decision he would have approved of. We never discussed it with him, obviously, but if he'd understood the situation, there would have been absolutely no question in Nicholas' mind that that's what he would have wanted us to do.

Hill: The letters chapter in the book is amazing. I was struck by your comment that it isn't possible to read those letters without the sense of a "momentous event" having taken place. I assume that's another example of the Nicholas Effect at work?

Green: Yes, on the face of it, it's just one tragedy among many. In terms of numbers, of course, Nicholas' death was a very small tragedy, and yet it had these amazing consequences. The letters we received weren't written the way condolences from strangers often are. They didn't write "We're sorry your little boy has died . . . He will be in our thoughts and you too . . . Goodbye." Instead, their letters talked about big things having happened in their lives because of this event. Some people felt their whole view had shifted, or that they'd taken some quite big action that they hadn't done before. They clearly felt that something had happened of importance that they should pay attention to.

Hill: Why? Why did this one death have that effect?

Green: Well, there must be a lot of elements to that. I think the slaughter of an innocent was part of it—the sheer wantonness of it all. And I think it probably had something to do with the fact that Maggie and I were willing to talk about it to the press right from the beginning, so that Nicholas' personality appeared in the very first stories that were written. He wasn't just figure with a name who was killed: he had a rounded personality. And because there were pictures, there was also a face to go with the story. I think also that having been a journalist, I knew that when you tell a story, you can't wait for two or three days to figure out what you feel about it, or to get it correct to the third place of decimals. You've got to talk right away. Another part of it was the reaction of Italy to it. It took the whole country by storm, and I think that regardless of what we did or didn't do, there would have been that explosion of sympathy. They were horrified that a child had been hurt, many were ashamed. The President and the Prime Minister made it into a national event. All those things together made it an event of importance. When we came back on one of the Italian President's planes, the press was waiting, and the momentum that Italy had given the story continued here, to a higher level still.

Hill: The force of that must have been astonishing to you.

Green: Yes, it was. By now we've grown used to people being moved by this story, but at the beginning we had no idea there'd be this reaction. I remember when we made the decision to donate the organs, we stayed to sign some forms, and then left the hospital. By the time we got back to the hotel, the press already knew. Until then we had thought we were making a purely private decision. Then by the next day there was a sheaf of telegrams from some of the leading figures in Italy.

Hill: As someone who has been a journalist, how well or how poorly did your colleagues in the media handle the story? They come off fairly well in the book, and I wondered if you were bending over backwards to be diplomatic.

Green: No. There were a lot of detailed mistakes, people getting our ages wrong and that sort of thing. A couple of magazines quoted us as saying that "Nicholas lives"—meaning he lives on through the organ recipients—and we never said that. But, as a whole, people treated the story seriously and they treated organ donation in a very mature and positive way. So we have nothing to complain about. In fact, I'm grateful to the press, because without the mass media this would have been a small story instead of a worldwide story.

Hill: It's unusual for anyone who's been the focus of media attention these days to come

out of the experience with much positive to say.

Green: I think they all felt very sorry for us. They didn't want to hurt us anymore.

Hill: How are the recipients doing?

Green: They're all back in the mainstream. There are seven of them and most are in very good shape. Let me think. The two who received corneas, yes, no problems there. Two kidneys, yes, Liver, fine, she just had a baby. So those five definitely. Now what have I missed? The boy with the heart, who had had six previous operations, he worried people for a time. He was in the hospital a lot longer than the others and there were side effects, and I remember hearing there were some concerns about rejection. However, a year or so ago I was on a TV program with his mother, and she said he's fine now. The seventh is Silvia, a long time diabetic, a brutal disease. She had been in a series of comas before her transplant and still has serious complications from that time. However, she has recovered enough that when I saw her last she was able to live in an apartment on her own.

Hill: How are Eleanor and the twins doing?

Green: Fine. Eleanor still says from time to time things like, "Wouldn't Nicholas have enjoyed this?" or, "Do you remember when Nicholas did that?" But the twins have changed her life beyond recognition. She had become an only child and we began to worry that she would turn inward. But the twins have brought out all her maternal instincts and she looks after them in a very mature way. They dote on her and love it when she comes home from school.

Hill: And Maggie is well?

Green: Yes, she's fine. Maggie's very strong. If you ever met Maggie, you'd see the gentleness in her, but it's the combination of that and the strength behind it all that's made all the difference.

Hill: What about you, Reg? I have read that you now consider increasing awareness of the need for organ donations as your life's work. Is that accurate?

Green: Yes, that's true. What this has given us is a genuine cause that has got two things going for it. One is, we know it does good. We can feel it in the air when we go places—the things people say to us, the statistics in Italy, the letters we get—we just know that it's having the kind of results we want it to have. Secondly, even though we're amateurs in the world of organ donation, and tens of thousands of other people working on this problem know infinitely more about it than we do, I do feel we have a special message.

Hill: My last question is really about the impact of the Nicholas Effect on you. You said at one time that "while we lost everything, we did get something back." What was it you got back?

Green: I suppose the nub of it is knowing so much good came out of what could easily have been just a sordid tragedy. I often think people don't realize, as we didn't, what a mighty gift they have in their hand when they are faced with a decision about making a donation.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. GREEN).

Mr. GREEN of Wisconsin. Mr. Chairman, I thank the gentleman for yielding me this time.

I would like to begin by associating myself with the remarks of my friend and colleague from Milwaukee and congratulate both he and my other colleague from Milwaukee (Mr. KLECZKA) for bringing this amendment forward.

This is the "good news amendment" of this process. Up to now, our debate, our battle has been over how to arrange the chairs around the table. This amendment is the first amendment that takes square-on the important challenge of how we make the table bigger, of how we make sure that we have more organs in the donor system.

□ 1500

As we have heard several times today, there is a sad shortage, and the shortage is a matter of life and death. But the good news is that in some parts of the country, like my home State and the gentleman's home State of Wisconsin, we have shown that public education and outreach efforts can work. We can increase the percentage of those who donate their organs. We can raise public awareness.

This amendment is so important because it turns to the States and it challenges the States, and works with and reaches out to the States to do what States like Wisconsin have done so we are not bickering over who sends what where, who will make these decisions, whether or not we are going to bring politics into this, turn this over to bureaucrats.

Instead, we can increase the number of organs donated, number of organs in the system, and that is really what this should be about today. That is the most important thing.

Again, I congratulate my colleague for bringing this amendment forward.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield 3 minutes to my colleague, the gentleman from Wisconsin (Mr. KLECZKA), a coauthor of this amendment.

Mr. KLECZKA. Mr. Chairman, let me thank my colleague, the gentleman from Wisconsin (Mr. BARRETT) for yielding time to me.

Mr. Chairman, I rise not only to support the amendment, but also to support the underlying bill. The entire issue of organ donation is very near and dear to our family, for it was about 6 years ago that my brother received the gift of life. He received a new lung at a local hospital in my district. Without that, my brother would not be with us any longer, or his four children, or his wife.

When we start talking about the allocation of organs and changing the system, I take a very strong interest in that. It seems that, after listening to the debate from those who oppose the bill, it is more of a question of where the organs are harvested, where they are available, and the fact that they are not necessarily sent to areas of the country where they do not do a very good job of procuring organs.

I am saying the answer to that dilemma, to the most serious problem, is not to throw out the current system that works, but let us adopt the Barrett amendment, which provides more

Federal resources to educate and to try to provide more donations from individuals in our country.

It is a very simple step, Mr. Chairman. I wonder how many Members of Congress have affixed to their driver's license the organ donation sticker, or have signed on the back of the driver's license the fact that should something happen to us, our organs should be preserved and not let gone to waste?

The question here is, let us provide the same type of education and programming at States other than those who do a good job, like Wisconsin and Florida and Kentucky, to the other States like Pennsylvania and some others of Members who spoke on the floor today.

One of the Members previously in the debate indicated that there are organs available, so someone calls the local golf course. I thought that was a rather crass statement. No one is going to have an organ transplanted into the body because it is newer than what they got. It is not done like a set of tires on your car which would provide for more mileage for getting around. It is a lifesaving thing.

We are told of the sad statistics where 4,000 people a year die because there are no organs available. The waiting lists are in excess of 65,000 around the country. But Mr. Chairman, even in areas where the organs are available, those waiting lists are there, also. They are doled out on medical need. My brother would probably not have received the lung he needed to live if the decision was made in Washington, because what physician, what bureaucrat, is going to know his condition versus the doctors who have attended him for years and years while he waited?

So those 4,000 who passed away because of unavailability of an organ also come from States where the organs are available because they are not plentiful enough. Adopt the Barrett amendment, provide some needed dollars, so we all can enjoy the gift of life that some States might have a couple more than others.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Chairman, I rise as a cosponsor of the Barrett amendment. I would also like to thank the gentlemen from Wisconsin, Mr. KLECZKA and Mr. BARRETT, the cosponsors, the authors of the amendment, for this excellent amendment. I believe this amendment can do a great deal to improve our Nation's current organ donation system.

We have witnessed in several States innovative programs to encourage increased organ donations that have produced dramatic results. In my home State of Wisconsin, we have developed a highly successful organ donation system that has served as a model

throughout the country. I believe that Wisconsin has offered much to those States that currently lack high donation rates.

The Wisconsin State legislature just recently passed a bill requiring teenagers to take 30 minutes of instruction on organ and tissue donation as part of their drivers education program. It is innovative programs like these that keep our rates high.

In addition to this program, Wisconsin has also introduced legislation for a donor registry, and currently utilizes driver's license checkout programs, donor cards, and power of attorney for health care forms to encourage organ donation.

This amendment would provide a cooperative environment that shares successes and helps to diminish failures. We should seek to eliminate our national organ shortage by improving the donation rates in all States, not by penalizing States with more effective programs.

I, too, am an organ donor. On the back of my Wisconsin driver's license, I have this great little sticker. We are doing well in Wisconsin. We have a program we are proud of. This amendment does a lot to improve the base text of a good bill to make sure that the States that are doing well continue to do well, and encourages those States that have room for improvement to improve themselves.

Mr. Chairman, I encourage all Members to vote in favor of the Barrett amendment.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield 2 minutes to the gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, in my home State, as Members have heard, we are blessed with one of the Nation's most successful organ transplant and procurement programs. People in Wisconsin care about helping their neighbors and loved ones, and we benefit from a very successful education and outreach program.

Everyone is involved in this effort, from families to physicians, small clinics and larger transplant hospitals. Additionally, the local media takes the time to emphasize and praise the actions of organ donors.

For instance, just this past weekend, one of my hometown newspapers featured a front page story on the recent tragic death of a 15-year-old boy in my district from a severe asthma attack. But even in the face of this awful tragedy, the family and the journalist made a point of noting the boy's commitment to organ donation.

Jason Frederick had talked about donating his organs. It was something he felt very strongly about. He wanted to be an organ donor, but he did not yet

have his driver's license. His family made sure that his wishes were carried out.

Rules and regulations at the Federal level addressing organ allocation will not address the critical issue of organ shortage. That is why this bill and the Barrett-Klecicka amendment are necessary. I am a cosponsor of this amendment because I want all States across the country to share Wisconsin's success in organ procurement and transplants.

I urge my colleagues to support this amendment and to provide States with the resources to address the underlying reason for the organ allocation problem in America today, the scarcity of donated organs.

Mr. BLILEY. Mr. Chairman, may I ask, do I have the right to close?

The CHAIRMAN pro tempore (Mr. EWING). Under the circumstances, the gentleman from Wisconsin (Mr. BARRETT) has the right to close, since the gentleman from Virginia (Mr. BLILEY) is not opposed to the amendment.

Mr. BLILEY. Mr. Chairman, I yield the balance of my time to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I want to just take a few seconds, really, to commend the gentleman from Wisconsin (Mr. BARRETT). He is on the committee, he is on the subcommittee, and he has heard all of the arguments and debate in the hearings.

In the process, unfortunately, of taking something which should have been worked out by the parties, and this is something we all were strongly hoping for and unfortunately it did not work out, because, as somebody said earlier today, we should not even really have to be doing something like this on the floor. The truth is that we should not have to, but we were forced to.

In the process of all that, however, many people said that what we really have to concentrate on is how to improve the harvesting of organs to get additional donations of organs and whatnot.

I think that the gentleman from Wisconsin (Mr. BARRETT) by his amendment is basically the only one who has addressed that at this point in time. We are hopeful we can work together to improve what he has come up with once this is behind us.

We want to commend him. I support his amendment and I want to publicly say so, particularly to commend him for coming up with these very innovative ideas. They do not go as far as we all would like them to go, but it certainly goes in the right direction. I want the gentleman to know that I appreciate it very much. I do commend the gentleman.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to thank the gentleman from Florida. I wish he had more time, because he is so nice to me.

Mr. Chairman, I yield 2 minutes to the gentleman from Wisconsin (Mr. KIND).

Mr. KIND. Mr. Chairman, I thank my friend for yielding me this time.

For someone just tuning in, Mr. Chairman, they are probably a little surprised to see that we are not actually debating dairy policy right now. Instead, we are talking about the organ donation system in the country. That is because it is very important for the people in Wisconsin, but it is actually as important for people across the country.

I know most of the Members here today are approaching this based on the very local and parochial viewpoint on the issue, but hopefully all of us can see the need and agree to support this very important amendment. I commend my friends, the gentlemen from Wisconsin, Mr. BARRETT and Mr. KLECZKA, for offering this.

This amendment is very simple. It establishes grants to States to foster public awareness, education, and outreach activities designed to increase the number of organ donors within the State. There is a shortage of organ donors across the States. I am very proud that my own State of Wisconsin has an excellent record of organ procurement. In 1999, the University of Wisconsin was one of the top organizations in organ procurement.

In fact, many States across the country including Alabama, California, Hawaii, Indiana, Missouri, Montana, and Texas, just to name a few, have implemented innovative programs to increase organ donation. In fact, Wisconsin has a model intensive education program that works closely with schools, community groups, church groups, and the hospitals to allay individuals' questions and concerns relating to organ donation.

This amendment recognizes the critical role that States can play and are playing in improving organ donation. I would urge my colleagues to support it.

Mr. BARRETT of Wisconsin. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN pro tempore. The question is on the amendment offered by the gentleman from Wisconsin (Mr. BARRETT).

The amendment was agreed to.

The CHAIRMAN pro tempore. It is now in order to consider amendment No. 5 printed in House Report 106-557.

AMENDMENT NO. 5 OFFERED BY MR.

SCARBOROUGH

Mr. SCARBOROUGH. Mr. Chairman, I offer an amendment.

The CHAIRMAN pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. SCARBOROUGH:

Page 29, after line 17, insert the following:

SEC. 8. NULLIFICATION OF FINAL RULE RELATING TO ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK.

Notwithstanding any other provision of law, the final rule relating to the Organ Procurement and Transportation Network, promulgated by the Secretary of Health and Human Services and published in the Federal Register on April 2, 1998 (63 Fed Reg. 16296 et seq. adding part 121 to title 42, Code of Federal Regulations) and amended on October 20, 1999 (64 Fed. Reg. 56649 et seq.), shall have no force or legal effect.

Page 29, line 18, redesignate section 8 as section 9.

The CHAIRMAN pro tempore. Pursuant to House Resolution 454, the gentleman from Florida (Mr. SCARBOROUGH) and a Member opposed each will control 15 minutes.

Is there a Member opposed to the amendment?

Mr. BROWN of Ohio. Mr. Chairman, I rise in opposition to the amendment.

The CHAIRMAN pro tempore. The gentleman from Ohio (Mr. BROWN) will be recognized for 15 minutes.

The Chair recognizes the gentleman from Florida (Mr. SCARBOROUGH).

Mr. SCARBOROUGH. Mr. Chairman, I yield myself 5 minutes.

Mr. Chairman, first of all, I rise in strong support of this bipartisan legislation, which obviously is going to reorganize the National Organ Transplant Act of 1984. It is a critical piece of legislation that will obviously save lives, and I want to say right now that I certainly heartily support the bill. I want to thank the gentleman from Virginia (Mr. BLILEY) and the gentleman from Florida (Mr. BILIRAKIS) for their hard work on the bill.

The Scarborough-Thurman amendment is actually a friendly amendment that preserves the use of real science and medicine in allocating organs. It keeps organ allocation out of the hands of Federal bureaucrats and keeps it with local doctors and also with local communities.

Unfortunately, in 1998, a bureaucratic rule was passed that tried to centralize all the power in the Department of HHS, and also centralize all of the decision-making authority with Donna Shalala and her bureaucracy. It was nothing less than a hijacking of the process, and today, as we talk about passing this important, critical bipartisan legislation, it is important to remember that this centralizing rule that allows bureaucracies to make decisions and not local doctors and local hospitals, local medical providers, and local communities, is still in effect.

□ 1515

The recent Institute of Medicine study concluded that the current organ transplant system is fair and does a very good job of acquiring and allocating organs for transplantation. However, like any system there is room for improvement but those decisions for improvement should be made by the people who are best equipped to

make the decisions, the transplant community rather than the HHS bureaucracy.

My amendment clarifies that the authority to set transplant policy rests with the transplant community and results from bottom up consensus driven processes, not by a regulatory fiat.

The Institute of Medicine also contradicted the underlying rationale for the controversial rule on organ allocation proposed by the Department of HHS. In an analysis of 68,000 liver patient records, the IOM panel said, quote, the overall median waiting time that patients wait for organs, the issue that seems to have brought the committee to the table in the first place, is not a useful statistic for comparing access to or equity of the current system of liver transplantation, especially when aggregated across all categories of liver transplant patients.

HHS has vigorously maintained that reducing regional differences in waiting time was the primary goal of the rule on organ allocation, but the practical effect of the rule would be to shift organs that are currently used for transplants in many local or regional transplant centers across the country to just a few very large national centers. This centralization of the process in Washington, D.C. could mean that patients waiting for a transplant at a local center are going to have to wait much longer or actually have to relocate closer to a national center if they hope to get the transplants that they so desperately need.

Now, for many patients, particularly poor, lower income patients, this could present a formidable economic obstacle for them and their families. To make matters worse, States where these national centers are located may not accept Medicaid from the patient's home State. Again, who is penalized? It is the low-income patient. The policy mandated by HHS will impair access to transplantation services for these low-income patients and lack of access to organs may drive some regional transplant centers completely out of business, inflicting a fundamental blow to patient access and, most importantly, to patient choice.

Congress must step in and act to assure that allocation policies that have been developed will not harm patient access to local transplantation services. The amendment that the gentleman from Florida (Mrs. THURMAN) and I would offer simply nullifies the final rule issued by HHS Secretary Donna Shalala that gives HHS the sole, centralized bureaucratic authority to approve or disapprove organ allocation policies that are currently established by the private sector transplant community.

It just makes absolutely no sense to centralize this process in one Washington bureaucracy and basically dictate what transplant centers across this Nation will do.

The Shalala rule is a bad rule. It makes no sense. It hurts those that are the lowest income transplant patients and, most importantly, it hurts choice.

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

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in strong opposition to the Scarborough amendment. The Department of Health and Human Services has worked with the transplant community and with UNOS to develop a final rule that reflects the Institute of Medicine recommendations, that reflects common sense.

On what basis should this body nullify those months of work, those hours and hours of time put in by HHS and outside experts?

Let me quote William Payne, MD, the President of UNOS. Dr. Payne, from listening to the debate today, must be quite a special man. After all, proponents of H.R. 2418 are comfortable bestowing upon him authority over matters critical to the public interest and to public health and to ensure that his decision-making is unencumbered by accountability to the public.

Let me quote Dr. Payne. In a letter he wrote a couple of weeks ago to my friend, the gentleman from Michigan (Mr. DINGELL) Dr. Payne said, quote, UNOS and HHS are working closely together to ensure an effective and efficient implementation of the Department's final rule, including the organ allocation provisions.

Let me read that again. UNOS and HHS are working closely together to ensure an effective and efficient implementation of the Department's final rule, including the organ allocation provisions, unquote.

So, even the President of UNOS seems supportive of HHS rule. So why should we overturn those rules?

Mr. Chairman, HHS has worked hard to ensure the final rule reflects Institute of Medicine recommendations. HHS has worked hard to ensure that the final rule reflects the views of patients, of donors, of the medical community, and the current contractor handling organ allocation.

The only reason, the only reason to nullify the HHS rule, is to perpetuate inequities in the system that we have heard so much about today and the lax oversight that has allowed these inequities to become entrenched in our organ allocation system.

Proponents of H.R. 2418 claim that HHS is engaging in a power grab. I maintain HHS is claiming, on behalf of the public, on behalf of taxpayers whom it represents, authority that does not belong to a private contractor.

Again, the right way to serve the public interest is not to protect a private government contractor from public input. It is to ensure that private

and public interests work together to build the best, most equitable system possible. That is the fundamental principle articulated in the Institute of Medicine report, and it is a defining principle underlying the HHS final rule.

I urge my colleagues to oppose the Scarborough amendment, which undercuts both IOM, Institute of Medicine findings, and a final rule that is thorough and is fair.

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

Mr. SCARBOROUGH. Mr. Chairman, I yield 1 minute to the gentleman from Virginia (Mr. BLILEY), the chairman of the committee.

Mr. BLILEY. Mr. Chairman, I thank the gentleman from Florida (Mr. SCARBOROUGH) for yielding me this time.

Mr. Chairman, I rise in support of this very straightforward Scarborough-Thurman amendment which nullifies the administration's organ regulation. This amendment clarifies for HHS that once H.R. 2418 becomes law, the Department must issue a new regulation to comport with the new authorization and to include lessons learned from 2 years of fighting with Congress.

I encourage my colleagues to join me in voting yes on the Scarborough-Thurman amendment.

Mr. BROWN of Ohio. Mr. Chairman, I yield 5 minutes to the gentleman from Pennsylvania (Mr. KLINK).

Mr. KLINK. Mr. Chairman, I thank the gentleman from Ohio (Mr. BROWN) for yielding me this time.

Mr. Chairman, this is a difficult issue because we have good friends who we respect on both sides of this amendment, on both sides of this bill. We come to our decisions with very deep and heartfelt life experiences that we have seen. This, I think, unlike most other pieces of legislation that we should argue and debate about, many of us have had firsthand experience.

I kind of grew up professionally, before I was a Member of Congress, I was in the news media in Pittsburgh and knew and still know Dr. Thomas Starzel, who is the father of much of the transplant technology that we have not only across this Nation but around this world.

The University of Pittsburgh, where Dr. Starzel and many of the other doctors who he trained and they trained other doctors, really went from an infancy of transplanting where there was seldom people that really survived for very long to the point where it is almost as commonplace as changing a carburetor in an automobile or an engine in a truck or a car to change major body parts and have people survive.

What a miraculous and historic time we live in.

The question here is, who plays God? Let us not make any questions or any qualms about this. It is, where is the

authority? The question is, do we take a private contractor, UNOS, and allow them to be the sole decision maker here? Or is there some government oversight?

I have heard much of the rhetoric today that we do not want some centralized, bureaucratic decision-making process based here in Washington, D.C. Well, that is what we typically call folderol in western Pennsylvania, because there is certainly not any monopoly on bad decision-making process in government.

I have been the ranking Democrat on the Subcommittee on Oversight and Investigations that has jurisdiction over, among other agencies, the Health Care Finance Administration. As we looked at the fiscal intermediaries, those insurance companies that we put in place to handle Medicare payments to hospitals, we found vast numbers of them that have ripped off the system for tens of millions of dollars. They have paid criminal and civil penalties for doing it. They have admitted their guilt.

We must have some government oversight. As I said earlier when we were debating the LaHood amendment, we depend on the Secretary and the agency to help us determine what medicines and what medical devices are safe and to tell us what the NIH criteria should be for research, what Medicare should cover. Now all of a sudden we want the government out and we want a private contractor making all of these decisions.

One cannot talk very badly, when they talk about the transplants, about the so-called national centers, whether it is at Pittsburgh, Stanford University, Cedar Sinai because these centers, and I have seen it firsthand, accept the sickest patients, patients quite often that would not be accepted for transplant in some of the smaller institutions around the country.

They accept people not just from their State, not just from their geographic location but from everywhere. We have seen circumstances where patients would come to the University of Pittsburgh, for example, and would not be able to get an organ from their home State because that State wanted to keep those organs in that State. We are simply talking about Health and Human Services, the Federal Government, working with UNOS, working with the transplant community, to set up a better, more definitive decision-making process. It does not have to be all one way or all the other way.

We cannot put private contracting agencies, with no recourse, with no checks and balances, in the position of playing God. That is what this amendment would do.

I must rise in strong, strong objection to this amendment, and I hope that there are Members who are not here that are watching on their TVs in their offices and that they will come

here and vote against this amendment. It is not because I have an objection to the authors. I think that they have offered this with the best of afthought, but on this, Mr. Chairman, we have a very deep-seated disagreement, and this amendment should be voted down.

Mr. SCARBOROUGH. Mr. Chairman, I yield myself 30 seconds.

Mr. Chairman, I would say, first of all, it sounded to me like we were really having to choose between two false choices there because right now the Federal Government does have oversight. HHS does have oversight. It had oversight when this bill was passed into law in 1984.

HHS has oversight, but what has happened now is oversight is not enough. They want to completely hijack the process. They want to be able to dictate whether somebody that dies in the Congressman's district near Pittsburgh can get an organ transplant in Pittsburgh or whether they decide they are going to have to go to Stanford University in California. It is unfair to the poorest people and it is wrong. Donna Shalala does not have a right to hijack the process.

Mr. Chairman, I yield 5½ minutes to the gentlewoman from Florida (Mrs. THURMAN).

Mrs. THURMAN. Mr. Chairman, I thank the gentleman from Florida (Mr. SCARBOROUGH) for yielding and I want to say that he has done a lot of hard work on this and I am proud to be standing here as a cosponsor with him on this floor today.

Mr. Chairman, I am rising in strong support of the underlying bill, H.R. 2418, but as well to this amendment. Some people might say well, why do we have to have this amendment when the bill reauthorizes the pre-HHS rule organ policies? Well, the truth is that this bill will reauthorize and strengthen the organ policies of our country. However, the HHS rule will still be in place and we would need to nullify that rule in order to turn these decisions back over to medical doctors.

So if one is for this underlying bill, they need to be for this amendment.

We have talked about that there are more than 63,000 Americans who are awaiting an organ transplant and each year about 4,000 Americans die because there are not enough donated livers, kidneys, and other organs to go around.

□ 1530

I just might insert here that, under the Health Resources and Services Administration, while they go through talking about reasons that we should improve the Nation's organ transplant, this is a part of HHS, the very last statement that they make is: the primary problem remains the shortage of organs available for transplantation. Absolutely the bottom line of all of

this. So we all agree that we must increase the number of organ donations in our country. However, not all of us agree on how to do this.

The Department of Health and Human Services believes the way to solve the problem is to move the organs from one part of the country to another. Although many people think this may help the organ shortage problem, do my colleagues know what I think? I believe this will only change the demographics of where people will die.

As long as there is an unequal number of patients needing transplants compared to organs available, people are going to die.

I do not disagree with Secretary Shalala's assertion that people in different areas of the country are waiting for different lengths of time. However, I have to insert here that it is important to remember that the very sickest patients, those who are in intensive care units, the current waiting period among all transplant centers is very short, less than 6 days in all regions of the country, in all regions of the country. This was publicly acknowledged by HHS officials at the same time that they issued the regulations.

However, we also do not believe, or that it is clearly an oversimplification to think that reallocating the available organs will have a positive impact on the outcome. UNOS says history shows that organ donation is a local phenomena. Organ donations rise in communities that have transplant centers and fall when centers close.

I have also heard several Members rise and talk about how lower-income individuals are not receiving organs in a timely manner. First, my colleagues should know that income is not taken into consideration when a patient is put on a transplant list.

Also, my colleagues should know that HHS regulations could have a negative impact on individuals who will have to travel great distances and be separated from their loved ones at a time when they are needed most.

Under the HHS rule, the additional travel cost could make it impossible for the 20 percent of transplant patients who are on Medicaid actually who would receive a transplant. Now, how would this happen? Because we think, if this rule stays in place, that in fact there would be centers in their communities that actually would close.

I also have to tell my colleagues, with the rule, there is a further problem generated by these regulations, one that was never taken into account; and that is the patients will have to become extremely ill before they receive a transplant. However, under the current rules and the UNOS policy, an individual's likelihood for a successful transplant is taken into consideration.

Why should the Secretary have the power to determine who gets an organ?

UNOS, along with the medical community, needs to determine who needs the organs the most and who will most likely be a successful transplant recipient.

My State of Florida has done an incredible job of increasing the number of individuals who agree to be an organ donor. Why should my State and my local transplant centers be punished for doing a good job? Why should the Federal Government dictate that someone who is a status 2 patient in another State should get an organ before a status 2 patient in Florida?

Allocation policies must be based on sound medical decisions, decisions made by the board of UNOS, not decisions handed down by the Federal Government.

My colleagues might also be interested to learn that kidneys must be compatible, and I do have personal experience on this. With regard to the liver, UNOS has recently taken steps to approve a new liver allocation plan which calls for developing new, more objective criteria for listing patients in the progressive illness categories.

The bottom line is we need to pass this amendment. If my colleagues agree with the underlying bill, then this amendment is what is needed so that we can make sure of what the gentleman from Ohio (Mr. BROWN) said, that UNOS and the Department can sit down and come up with one that is more aggressive for everybody.

Mr. BROWN of Ohio, Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to recap sort of where we have been with this controversy in the last couple of years. Two years ago, almost exactly to this day, in early April of 1998, HHS promulgated what was called the final rule at that point on this. Soon after, our colleague who has since left, Mr. Livingston, inserted or added in the appropriations process a rider calling for an Institute of Medicine study and saying that he was particularly unhappy, as many Members of Congress were, in some cases legitimately, with what had transpired and with the HHS rule.

The Institute of Medicine study came up with several interesting things. This is the study I hold here. It is 200 pages. It is clearly well thought through and well considered and well constructed with good recommendations. This Institute of Medicine study was factored into revised rules by HHS. The proposed finalized, revised version, which was issued October 20, 1999, included IOM rules. It included some of the considerations and ideas from the public. It included input from UNOS.

That is why, in the end, that Dr. Payne, and I said this earlier, why Dr. Payne, the President of UNOS, has written that UNOS and HHS are working closely together to ensure an effective and efficient implementation of

the Department's final rule set for March 16, including its organ allocation provisions.

That is exactly the point. HHS issued a rule. Congress stepped in, said we need this IOM study. We got this IOM study. The study from the Institute of Medicine was incorporated in the new HHS rule. In this proposed finalized, revised version issued October 20, other changes recommended by UNOS, recommended by the public were incorporated.

That is why the very respected Dr. Payne, who is head of UNOS, said that UNOS and HHS is working together. That is why we should oppose this amendment. That is why we should oppose this bill if the amendment is incorporated.

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

Mr. SCARBOROUGH. Mr. Chairman, can I inquire how much time each side has remaining.

The CHAIRMAN pro tempore (Mr. HOBSON). The gentleman from Florida (Mr. SCARBOROUGH) has 3½ minutes remaining. The gentleman from Ohio (Mr. BROWN) has 5½ minutes remaining.

Mr. SCARBOROUGH. Mr. Chairman, I yield 1 minute to the gentleman from Alabama (Mr. BACHUS).

Mr. BACHUS. Mr. Chairman, March 16, 2000, that was last month. It was a Thursday. HHS and Donna Shalala decided that they knew better than doctors, they knew better than hospitals, they knew better than the entire transplant community. They substituted their opinion for that of patient, for doctor, family, and decided that they would make the call that their opinion was what counted when it came to transplants. It was a day on which they issued a rule that threatens the health of tens of thousands of Americans.

This amendment is necessary because we need to send a strong signal, this body, that medical decisions are not made by Federal bureaucrats that do not have a medical degree. They are made by the medical community. They are made by the hospital. They are made by the patients.

This amendment is a good amendment. On three occasions, the Congress has voted to stop that rule. It is time to put a stake through the heart of that ill-conceived rule.

Mr. SCARBOROUGH. Mr. Chairman, do I have the right to close?

The CHAIRMAN pro tempore. The gentleman from Ohio (Mr. BROWN) has the right to close.

Mr. SCARBOROUGH. Mr. Chairman, I yield the remaining time to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Chairman, I support the amendment, and I am in support of the final passage of the basic bill.

Really, the transplant community has put it a lot better than any of us

could. I would like to just share with my colleagues some excerpts from some of their comments. "A 'sickest first' policy would increase the number of retransplants as more patients experience graft rejection, and thus reduce the number of organs available for transplantation overall. Patients would have to become 'sicker' in order to receive a transplant, thus reducing their chance for survival. This would be completely counterproductive and result in increased cost with reduced success." I quote Dr. R. Robert Higgins, Director of Thoracic Organ Transplantation, Henry Ford Hospital in Michigan.

He went on to say, "A national list coupled with a sickest-first policy would make it all but impossible for my patients and in particular patients everywhere that are poor or minority patients, to receive a transplant. From a physician's point of view, without available organs, there is nothing I can do to help my patients over the longer term. If the rule were in effect today, the Federal Government would essentially be denying the benefits of organ transplantation to a broader number of patients." Dr. Higgins of Henry Ford Hospital made those comments.

Joseph Brand, chairman of the National Kidney Foundation: "We believe that less patients would receive liver transplants if the OPTN were required to develop policies where organs are allocated to the sickest candidates first. Such candidates are likely to have poor outcomes and require repeat transplants, thus reducing the number of organs available for other candidates. Furthermore, NKF has maintained that a 'sickest first' policy should not be applied to renal transplantation because of the availability of dialysis as an alternative therapy."

Mr. John R. Campbell, senior vice president and general counsel of LifeLink says, in talking about the great instances of the donations: "First, costs will dramatically increase, because of the required private jet transportation of hearts and livers. Second, 'warm' time," W-A-R-M time, "or the time from organ procurement to implantation, will increase, and thereby decrease the function of the organs. This will also increase costs. The patients at the 'top' of the transplant list are very sick, and do not do as well with their transplants as other patients. Therefore, retransplants will increase because very sick patients are more likely to experience rejection of the organ, and transplant hospital stays will increase."

Mr. Chairman, I include all of these comments for the RECORD as follows:

ADMINISTRATION REGULATION WOULD HURT
ORGAN SUPPLIES

QUESTION POSED FOR APRIL 15, 1999 HEARING ON:
PUTTING PATIENTS FIRST: INCREASING ORGAN
SUPPLY FOR TRANSPLANTATION

The proposed HHS regulations to reallocate organs state that "the OPTN is required

to develop equitable allocation policies that provide organs to those with the greatest medical urgency, in accordance with sound medical judgment." When President Clinton signed H.R. 3579, the Supplemental Appropriations and Rescissions Act, on May 1, 1998, which extended the public comment period and implementation deadline for the HHS OPTN regulations, he issued a written statement in opposition to extending the comment period on the rule. In stating his reasons for opposing the extension, President Clinton stated that "The final rule would ensure that organs are allocated to the sickest candidates first." What would be the supply-side effects of a policy where organs were to be allocated to "the sickest candidates first"?

RESPONSES

"A 'sickest first' policy would increase the number of re-transplants as more patients experience graft rejection, and thus reduce the number of organs available for transplantation overall. Patients would have to become 'sicker' in order to receive a transplant, thus reducing their chance for survival. This would be completely counterproductive and result in increased cost with reduced success."—Dr. R. Robert Higgins, Director of Thoracic Organ Transplantation, Henry Ford Hospital.

"The supply-side effects would result from the increased transplant of sicker patients, at great distance from the location of the donation. First, costs will dramatically increase, because of the required private jet transportation of hearts and livers. Second, 'warm' time, or the time from organ procurement to implantation, will increase, and thereby decrease the function of the organs. This will also increase costs. The patients at the 'top' of the transplant list are very sick, and do not do as well with their transplants as other patients. Therefore, retransplants will increase because very sick patients are more likely to experience rejection of the organ, and transplant hospital stays will increase. Data indicates that a new allocation scheme would substantially increase organ wastage. Also, in States like Florida, the hard work and dramatic success of our local and state organ donation partnership will be diluted by siphoning organs to out-of-state transplant centers. We believe donor families are more likely to donate knowing that the organs will benefit their local community. But we also believe that the staff responsible for acquiring consent and arranging the logistics of organ donation are also motivated by the knowledge that patients in their community are being helped by their hard work. The immediate results are apparent to everyone involved, and give them the greatest incentive to work at their maximum efficiency."—John R. Campbell, P.A., J.D., Senior Vice President and General Counsel, LifeLink.

"We believe that less patients would receive liver transplants if the OPTN were required to develop policies where organs are allocated to the sickest candidates first. Such candidates are likely to have poor outcomes and require repeat transplants, thus reducing the number of organs available for other candidates. Furthermore, NKF has maintained that a 'sickest first' policy should not be applied to renal transplantation because of the availability of dialysis as an alternative therapy."—Joseph L. Brand, Chairman, National Kidney Foundation, Office of Scientific and Public Policy.

"UNOS modeling of a 'sicker patient first' policy indicates that more organs would be wasted and fewer patients transplanted with

poorer overall results. Unfortunately, sicker patients are more likely to die or lose their transplants to post operative complications. My experience in the private practice of medicine for over 25 years, taught me early on that I couldn't 'cure' everyone; that, unfortunately, not everyone would ever have equal access to medical care, and one had to learn to deal with 'the hand you were dealt.' It is, and always will be, an imperfect world."—Robert A. Metzger, M.D., Medical Director, Translife.

"The ASTS has made it clear that we believe the impact of such a 'sickest first' policy would be contrary to our goal of insuring that the precious organs presently available provide the maximum benefit to the maximum number of Americans in an equitable fashion. This point was made in testimony presented at two previous Congressional hearings by Dr. Ronald W. Busuttil, President-elect of the Society and director of the world's most active liver transplant center in UCLA, and I am submitting copies of his testimony with this response. I also include a copy of our written testimony to the Institute of Medicine, presented by Dr. Busuttil on April 16th, which expands on these points. Unfortunately, critical care medicine and vital organ transplantation is not an exact science. That is why a significant number of Status 3 liver patients, those thought to be the least sick, die while in that status. We urge the Congress to leave decisions of this kind in the hands of the medical professionals—who battle these life-and-death issues with their patients every day—and not permit them to be imposed by governmental authority far from the trenches where life and death is played out. The simple answer is that there are some changes that must evolve in the distribution of life-saving organs for transplantation, as they have evolved in the past. This can be accomplished with the help of the federal government, but not with the implementation of a radically new OPTN rule which with its current inferences, language, and preamble has resulted in soundbites such as 'sickest patients first.'"—Joshua Miller, M.D., President, American Society of Transplant Surgeons.

"This has been discussed in detail by PAT Coalition. Allocation to the 'sickest first' on a national level will increase wait list mortalities, waste organs, increase retransplantation rates, disadvantage medically and economically disenfranchised segments of the population by limiting access to transplantation for indigent patients as smaller centers are forced to close their doors. The organs would be diverted to the most critically ill patients first, regardless of their location. While this may sound like a fair and reasonable way to allocate organs, a policy such as this may actually result in lost lives. The immediate and long term survival of liver transplant recipients is directly dependent on their preoperative condition, with significant decompensation adversely affecting survival. Blindly applied legislation may mean that a significant number of organs are given to people with little chance of survival. Organs may not become available for others until they too are critically ill with little chance of survival."—Amadeo Marcos, Assistant Professor of Surgery, Director of the Living Donor Liver Program, Division of Transplantation, Medical College of Virginia.

"We believe that the current system of policy development is sound. It is based on consensus building and medical judgement. Major changes to the liver and heart allocation policies have been instituted during the

past two years by the Organ Procurement and Transplantation Network ('OPTN') contractor, the United Network for Organ Sharing ('UNOS'). This includes standardized listing criteria for patients and changes to the status designations for liver and heart patients. We believe that the current system, while not perfect, is designed to ensure that the sickest patient is offered the organ first. We know in our region that the vast majority of patients receiving heart and liver transplants are transplanted at the highest level of acuity and are the sickest patients in our region. We believe that further changes to mandate a single national list for allocation, may lead to organs being wasted and potential donors lost given the attendant medical and social issues."—Howard M. Nathan, President and Chief Executive Officer, Coalition on Donation.

ADMINISTRATION REGULATION WOULD HARM LOCAL ACCESS TO TRANSPLANT SERVICES
QUESTION POSED FOR APRIL 15, 1999 HEARING ON:
PUTTING PATIENTS FIRST: INCREASING ORGAN SUPPLY FOR TRANSPLANTATION

In your estimation, how would the Department of Health and Human Services regulations published April 2, 1998, affect your patients and your ability to provide the highest quality of medical care for them? What impact will this rule have on local access to transplant services nationwide?

"A national list coupled with a sickest first policy would make it all but impossible for my patients and in particular patients everywhere that are poor or minority patients, to receive a transplant. From a physician's point of view, without available organs, there is nothing I can do to help my patients over the longer term. If the rule were in effect today, the federal government would essentially be denying the benefits to organ transplantation to a broader number of patients."—Dr. R. Robert Higgins, Director of Thoracic Organ Transplantation, Henry Ford Hospital.

"We believe that our local transplant center patients will be significantly and negatively impacted, as will the vast majority of the country's 120 liver transplant centers. Donated livers will be sent from Florida to a half dozen urban regional transplant centers—none of which are in the southeast. Our community will be deprived of this life-saving resource, a resource which our local citizens and the community have developed together. Highly skilled doctors and nurses will no longer perform the same number of transplants. Local centers may be forced to close their doors. In addition, access for low-income patients may be decreased. Medicaid patients may be unable to obtain transplants outside their home state, and other patient families may not be able to accompany their loved one to support them at a faraway transplant center. Also, organ donation will be affected. Many donor families have stated that a key factor in their decision to donate was the knowledge that they would be helping someone within their community. Eliminating this motivation may substantially reduce voluntary organ donation nationwide."—John R. Campbell, P.A., J.D., Senior Vice President and General Counsel, LifeLink.

"We are concerned that the April 2, 1998 regulations have politicized the organ donation/organ allocation process since they give the DHHS Secretary veto power over OPTN Policy. Transplantation should be based upon medical science, not politics. We are concerned that the rule may cause some local transplant centers to close and that

would make it difficult for low income transplant candidates to receive a transplant. Such candidates may not be able to afford to travel to distant transplant centers for evaluation, the transplant itself and post-operative care and testing."—Joseph L. Brand, Chairman, National Kidney Foundation, Office of Scientific and Public Policy.

"The Health and Human Services rule that would mandate 'broader' sharing would result in increased waiting times for Florida recipients as our patients currently have shorter waiting times when compared to the national averages. This could potentially lead to further deterioration in their health prior to transplantation. Local access to local organs, the optimal transplant situation, would occur less frequently."—Robert A. Metzger, M.D., Medical Director, Translife.

"In general the rule as currently written will impact negatively upon patients nationwide. I personally work in a large transplant center, one of the five largest in the world, and am proud of our record over the years. I also have been proud of our organ procurement agency, the University of Miami OPO. This has repeatedly over the years had one of the most enviable records nation- and worldwide in organ retrieval for life-saving transplantation. This is due to our local OPO Director, Les Olson, with whom I have had the privilege of working for 30 years, first in Minnesota, and then for over 20 years in South Florida. Please make no mistake. Organ donation is a local phenomenon dependent on the expertise of professional personnel. That also accounts for the great records in organ retrieval of Lifelink in West Florida, for Translife in Central Florida, and for the University of Florida OPOs. How could those who drafted the OPTN rule not acknowledge this? Some of the language in the OPTN rule also will have a negative impact on local access to service. I can expand on this, but I refer you to comments already made by our ASTS (enclosed). It is also worth noting that the vast majority of the written comments on the rule, collected by DHHS and not yet described by the Department, are understood to have been negative."—Joshua Miller, M.D., President, American Society of Transplant Surgeons, University of Miami School of Medicine.

"The portion of the April HHS rule which would create a national wait list will severely limit access to transplantation for the indigent population by forcing small and moderately sized centers to close their doors. This concept is designed to support only a select few very large transplant centers, which would regionalize access to transplantation to only a few places in the entire country. It is obvious that moderately sized centers, such as our own, not only can provide high quality transplant patient services, but also provide the innovative driving force required to develop something like a 'living donor adult-to-adult right lobe' liver transplant program, etc."—Amadeo Marcos, Assistant Professor of Surgery, Director of the Living Donor Liver Program, Division of Transplantation, Medical College of Virginia.

"Mandating a national allocation system for all organs is likely to spur growth at a few large centers in the country but may impact the viability of smaller programs. This may have the effect of reducing or inhibiting access to services by those recipients and their families who are not able to travel to large centers due to economic and other barriers. Additionally, mandating a national allocation system of organs will eliminate the

concept of local neighbor helping neighbor. Complete elimination of the concept of neighbor helping neighbor may adversely impact donation. Finally, a national allocation system disregards differences in medical judgment and opinion. It also disregards the practices of transplant surgeon who perform the organ recovery and view the organ in the donor patient and evaluate biopsy results (for livers) in order to evaluate suitability for transplant generally, as well as suitability for a specific recipient."—Howard M. Nathan, President and Chief Executive Officer, Coalition on Donation.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, people have sort of heard these debates and arguments on this over and over. I would just like to recap, not just on the Scarborough amendment, but sort of this whole debate, and ask my colleagues to vote "no" on Scarborough and "no" on final passage.

We have heard Dr. Payne's comments, the president and head of UNOS, and his comments about the importance of these pending negotiations. If my colleagues read what his comments said in his letter to the gentleman from Michigan (Mr. DINGELL) and his other comments, they can clearly see that he wants this process to go on, these negotiations to go on, and not particularly welcoming of congressional interference.

I would also add that we have inserted in the RECORD a statement from the President's advisors that they will recommend a veto on this legislation if, in fact, anything close to its present form reaches the President's desk.

We have also received a letter from the Justice Department reiterating that they strongly believe that this is unconstitutional; and if for some reason, which they do not think would happen, it is not declared unconstitutional, their belief is it shifts power in some sort of the wrong way from the Government to a private sector, private interest group that does not really have any public accountability.

Equally as important, Mr. Chairman, the main argument that the proponents of this bill have made, the proponents of the Scarborough amendment, is that this process, by turning over authority to UNOS, that this process will actually increase the number of donations, organ donations, which is the goal we all aim for.

I would cite from the Institute of Medicine on page 10: "The committee believes strongly that the effectiveness and productivity of organ procurement is highly dependent on good working relationships at the local level." That is clearly what we need to do. But they go on in spite of what we have heard from the other side to say: "However, our committee finds no evidence that broader organ-sharing arrangements will lead to reduced rates of donation." That if organs go farther across the

country, it simply does not affect people's proclivity to donate organs. What makes people want to donate organs is that they believe it will save lives.

The Institute of Medicine supports the role of HHS. The Institute of Medicine study here is included in the HHS rules. Shifting power from representatives of the people, from elected and appointed government officials to a private bureaucratic organization is the wrong way to go. The HHS rules will save lives.

We should vote "no" on Scarborough. We should vote "no" on final passage.

Mr. BILIRAKIS. Mr. Chairman, will the gentleman yield?

Mr. BROWN of Ohio. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, I really appreciate the gentleman yielding, because he knows I am going to rebuff some of what he has said.

Basically it is not a shifting of power. For 16 years, it has been UNOS, which is contracted, set up by HHS quite some time ago with the rights to terminate those contracts and that sort of thing.

□ 1545

So it is not a shift of power. In fact, the effort is being made to shift the power from this private agency contractor, from UNOS, back to the Federal Government. That is the shift.

The gentleman from Pennsylvania (Mr. KLINK) talked earlier about all of a sudden. Well, all of a sudden is really what has taken place here. Because for 16 years it was being done a certain way and, all of a sudden, HHS has decided to grab the power.

I appreciate the gentleman yielding.

Mr. BROWN of Ohio. Mr. Chairman, reclaiming my time and in closing, I would reiterate that there is no place in our entire government where the government has abdicated its responsibility and given this kind of authority, this kind of power, with so little government oversight to a bureaucratic organization that is not really accountable to the public.

That is why most of us on this side of the aisle ask for a "no" vote on the Scarborough amendment and a "no" vote on final passage.

The CHAIRMAN pro tempore (Mr. HOBSON). All time has expired.

The question is on the amendment offered by the gentleman from Florida (Mr. SCARBOROUGH).

The amendment was agreed to.

The CHAIRMAN pro tempore. The question is on the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr.

CHABOT) having assumed the chair, Mr. HOBSON, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2418) to amend the Public Health Service Act to revise and extend programs relating to organ procurement and transplantation, pursuant to House Resolution 454, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the committee amendment in the nature of a substitute adopted by the Committee of the Whole? If not, the question is on the amendment.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

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

Mr. BROWN of Ohio. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 275, nays 147, not voting 12, as follows:

[Roll No. 101]

YEAS—275

Abercrombie	Bryant	Dicks
Aderholt	Burr	Doolittle
Allen	Burton	Dreier
Andrews	Buyer	Duncan
Archer	Callahan	Dunn
Armye	Calvert	Edwards
Bachus	Camp	Ehlers
Baird	Canady	Emerson
Baker	Cannon	Everett
Baldacci	Chabot	Ewing
Baldwin	Chambliss	Fletcher
Ballenger	Chenoweth-Hage	Foley
Barcia	Clement	Ford
Barr	Clyburn	Fossella
Barrett (WI)	Coble	Fowler
Barton	Coburn	Franks (NJ)
Bass	Collins	Frelinghuysen
Bateman	Combest	Frost
Bentsen	Cooksey	Gallely
Berkley	Cox	Ganske
Berry	Cramer	Gephardt
Bilbray	Cubin	Gibbons
Bilirakis	Cunningham	Gillmor
Bishop	Danner	Gilman
Bliley	Davis (FL)	Gonzalez
Blumenauer	Davis (VA)	Goode
Blunt	Deal	Goodlatte
Boehner	DeFazio	Gordon
Bonilla	DeGette	Goss
Bono	DeLay	Graham
Boswell	DeMint	Granger
Boyd	Deutsch	Green (TX)
Brady (TX)	Dickey	Green (WI)

Gutknecht	Matsui	Salmon
Hall (TX)	McCollum	Sandin
Hastings (WA)	McCrery	Sanford
Hayes	McDermott	Saxton
Hayworth	McGovern	Scarborough
Hefley	McHugh	Schaffer
Herger	McInnis	Scott
Hill (IN)	McIntosh	Sensenbrenner
Hill (MT)	McKeon	Shadegg
Hilleary	McKinney	Shaw
Hilliard	McNulty	Shays
Hinojosa	Meek (FL)	Shows
Hobson	Menendez	Simpson
Hoekstra	Metcalfe	Sisisky
Holt	Mica	Skeen
Hooley	Miller (FL)	Skelton
Horn	Miller, Gary	Smith (MI)
Hostettler	Mink	Smith (NJ)
Houghton	Moore	Smith (TX)
Hulshof	Moran (KS)	Smith (WA)
Hunter	Moran (VA)	Snyder
Hutchinson	Nethercutt	Souder
Inslee	Ney	Spence
Isakson	Northup	Spratt
Istook	Norwood	Stearns
Jackson-Lee	Nussle	Stump
(TX)	Obey	Sununu
Jefferson	Ortiz	Sweeney
Jenkins	Ose	Talent
John	Oxley	Tancredo
Johnson (CT)	Packard	Tanner
Johnson, E.B.	Pallone	Tauzin
Johnson, Sam	Pascrell	Taylor (MS)
Jones (NC)	Pastor	Taylor (NC)
Kaptur	Pease	Thomas
Kasich	Petri	Thompson (MS)
Kelly	Pickering	Thornberry
Kilpatrick	Pickett	Thune
Kind (WI)	Pitts	Thurman
Kingston	Pombo	Tiahrt
Kleczka	Portman	Traficant
Knollenberg	Pryce (OH)	Turner
Kolbe	Radanovich	Udall (NM)
Kuykendall	Ramstad	Upton
LaFalce	Regula	Vitter
Lampson	Reyes	Walden
Largent	Reynolds	Walsh
Latham	Riley	Wamp
LaTourette	Rivers	Watkins
Lazio	Rodriguez	Watts (OK)
Leach	Rogan	Weldon (FL)
Lewis (CA)	Rogers	Wexler
Lewis (GA)	Rohrabacher	Whitfield
Lewis (KY)	Ros-Lehtinen	Wicker
Linder	Rothman	Wilson
LoBiondo	Roukema	Wolf
Lucas (KY)	Royce	Wu
Lucas (OK)	Ryan (WI)	Young (AK)
Manzullo	Ryun (KS)	Young (FL)

NAYS—147

Ackerman	Dooley	Lantos
Baca	Doyle	Larson
Barrett (NE)	Ehrlich	Lee
Bartlett	Engel	Levin
Becerra	English	Lipinski
Bereuter	Eshoo	Lofgren
Berman	Etheridge	Lowey
Biggart	Evans	Luther
Blagojevich	Farr	Maloney (CT)
Boehlert	Filner	Maloney (NY)
Bonior	Forbes	Markey
Borski	Frank (MA)	Mascara
Boucher	Gejdenson	McCarthy (MO)
Brown (FL)	Gekas	McCarthy (NY)
Brown (OH)	Gilchrest	McIntyre
Capps	Goodling	Meehan
Capuano	Gutierrez	Meeks (NY)
Cardin	Hall (OH)	Millender
Carson	Hansen	McDonald
Castle	Hastings (FL)	Miller, George
Clay	Hinchee	Minge
Clayton	Hoeffel	Moakley
Condit	Holden	Mollohan
Conyers	Hoyer	Morella
Costello	Hyde	Murtha
Coyne	Jackson (IL)	Nadler
Crowley	Jones (OH)	Napolitano
Cummings	Kanjorski	Neal
Davis (IL)	Kennedy	Oberstar
Delahunt	Kildee	Olver
DeLauro	King (NY)	Owens
Dingell	Klink	Paul
Dixon	Kucinich	Payne
Doggett	LaHood	Pelosi

Peterson (MN)	Serrano	Towns
Peterson (PA)	Sessions	Udall (CO)
Phelps	Sherman	Velazquez
Pomeroy	Sherwood	Visclosky
Porter	Shimkus	Waters
Price (NC)	Slaughter	Watt (NC)
Rahall	Stabenow	Waxman
Rangel	Stark	Weiner
Roemer	Stenholm	Weldon (PA)
Roybal-Allard	Strickland	Weller
Rush	Stupak	Weygand
Sabo	Tauscher	Wise
Sanchez	Terry	Woolsey
Sanders	Thompson (CA)	Wynn
Sawyer	Tierney	
Schakowsky	Toomey	

NOT VOTING—12

Brady (PA)	Diaz-Balart	Myrick
Campbell	Fattah	Quinn
Cook	Greenwood	Shuster
Crane	Martinez	Vento

□ 1614

Messrs. OWENS, DOOLEY of California, PORTER, HINCHEY, and Mr. DELAHUNT changed their vote from "yea" to "nay."

Messrs. SHAYS, GILMAN, Mrs. MEEK of Florida, Ms. KILPATRICK, Mr. INSLEE, and Mr. MATSUI changed their vote from "nay" to "yea."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

□ 1615

AUTHORIZING THE CLERK TO MAKE CORRECTIONS IN THE ENGROSSMENT OF H.R. 2418, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK AMENDMENTS OF 1999

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that in the engrossment of the bill, H.R. 2418, the Clerk be authorized to correct section numbers, punctuation, and cross references and to make such other technical and conforming changes as may be necessary to reflect the actions of the House.

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

There was no objection.

GENERAL LEAVE

Mr. BLILEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to insert extraneous material on the bill, H.R. 2418.

The CHAIRMAN pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 3660, PARTIAL-BIRTH ABORTION BAN ACT OF 2000

Mr. LINDER, from the Committee on Rules, submitted a privileged report

(Rept. No. 106-559) on the resolution (H. Res. 457) providing for consideration of the bill (H.R. 3660) to amend title 18, United States Code, to ban partial-birth abortions, which was referred to the House Calendar and ordered to be printed.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 1824

Mr. MASCARA. Mr. Speaker, I ask unanimous consent to have my name removed as a cosponsor on H.R. 1824.

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

There was no objection.

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Mr. Sherman Williams, one of his secretaries.

REPORT OF THE CORPORATION FOR PUBLIC BROADCASTING—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committee on Commerce:

To the Congress of the United States:

As required by section 19(3) of the Public Telecommunications Act of 1992 (Public Law 102-356), I transmit herewith the report of the Corporation for Public Broadcasting.

WILLIAM J. CLINTON.
THE WHITE HOUSE, April 4, 2000.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

STATE DEPARTMENT HAS CERTIFIED CUBA AS CHILD-ABUSER

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

Mr. BURTON of Indiana. Mr. Speaker, I would like to refer to an article that was in Human Events on February 18 of this year entitled "State Department has Certified Cuba as a Child-abuser" country. And the article reads as follows, "the Clinton State Department's most recent annual human rights report describes Fidel Castro's Cuba as a vicious police state where children in particular are targeted for abuse by the government, but that, ap-

parently, means nothing to the Immigration and Naturalization Service, an agency of Attorney General Janet Reno's Justice Department, which remains determined to deny even an initial political asylum hearing to a 6-year-old Elian Gonzalez, the Cuban boy who arrived in Florida on Thanksgiving Day clinging desperately to an inner tube.

An INS spokesman told Human Events last week that the agency will not alter its position because of information in the State Department report. The INS has determined, said spokesman Maria Cardona, that the true will of the boy's father is that he be returned. Is it impossible, she asked rhetorically, that a little boy could grow up in a loving family in Cuba?

President Castro exercises control over all aspects of Cuban life through the Communist Party and the state security apparatus says the State Department report published in February 1999. A new report is due out in a few weeks.

Castro says the report uses agents of the Ministry of the Interior to investigate and suppress all public dissent. The agents recruit informers throughout Cuban society to create a pervasive system of vigilance. Jailed dissidents face a prison system designed to terrorize. Prison guards and state security officials says the State Department also subjected activists to threats of physical violence, systematic psychological intimidation and with detention or imprisonment in cells with common and violent criminals, aggressive homosexuals or state security agents posing as prisoners.

The report also cites widespread tuberculosis, hepatitis, parasitic infections and malnutrition in Castro's prisons. Prison officials, it says, regularly confiscate food or medicine brought to political prisoners by their relatives.

Short of imprisonment, Cuban dissidents are frequently targeted for systematic harassment campaigns or acts of repudiation. Castro routinely conscripts children, get this, conscripts children to participate in these campaigns in which neighbors, fellow workers and members of state-controlled organizations are corralled in front of a target's house. Once in place, they are coached to yell obscenities, damage property, and even physically attack the target.

In 1998, for example, Castro targeted the family of a journalist whom he ordered arrested for allegedly insulting him. Communist Party leaders and government officials conscripted local workers and grade school students and high school students to rally in front of the family's home and shout obscenities at the occupants before plainclothes security agents bashed down the door and beat family members.

Cuban youths are also forced to provide labor to the state. The government employs forced labor, including