

policies are doing, to see what kind of punishment.

Now, we know that taxes are necessary, but we doggone well better sit down and figure out which taxes are fair and necessary, and that is the trail that we should walk.

PATIENTS' BILL OF RIGHTS, PATIENT PROTECTIONS, AND HMO REFORM

The SPEAKER pro tempore (Mrs. CAPITO). Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes.

Mr. GANSKE. Madam Speaker, I appreciate the fervor and emotion that my colleague just spoke about, especially in dealing with the death tax situation, because we have many people back in my home State of Iowa that need this type of relief if, in fact, they are going to pass on their family farms to their children. The way that that tax is calculated and who the benefit goes to can be done many ways. One can say the benefit goes to the person who dies, and that person may have some considerable assets; but in actuality, it is the person who inherits that has to pay the tax, and if we look at who these people are, very, very frequently, they do not have assets. They are not rich, and then they end up having to sell off half of the farm in order to pay the Federal taxes. I think that needs to be fixed.

Madam Speaker, I want to speak tonight on an issue that I find emotional too, and that has to do with the Patients' Bill of Rights and patient protections as it relates to HMOs.

Madam Speaker, about a week ago I was in my apartment here in Washington watching C-SPAN; and there was a panel on, a panel of former Members of Congress, and they were being interviewed and giving comments about what they thought would happen this year in the legislative arena. And these pundits were giving their opinions on tax cuts and prescription drug benefits and other things, and then one of the panelists said something. He said, "You know, I think this deal about patient protection doesn't need to be done. You know, I really don't know anyone who has been harmed by HMOs." Madam Speaker, I nearly fell off my sofa. I nearly fell off my sofa when this pundit, this former Member of Congress said, "You know, who needs patient protection, HMO reform because, after all, nobody is being hurt." I thought to myself, what world is that man living in? What world is that man living in?

I thought, does he not read the newspapers? Does he not see stories like this: "What his parents didn't know about HMOs may have killed this baby." Maybe this former Member of Congress, who I happen to know; he is

a friend, he is a fine man, but I am thinking to myself, how could he make this comment?

Does he not see newspapers like this: "HMOs' cruel rules leave her dying for the doc she needs." Where has he been?

Madam Speaker, before coming to Congress, I was a reconstructive surgeon. I took care of lots of babies that were born with congenital defects like this cleft lip and cleft palate. Fifty percent of the reconstructive surgeons in the country in the last 2 years have had cases like this denied by HMOs as not being medically necessary. What world does that man live in? I thought to myself, well, maybe he does not read the national news magazines. Maybe he did not see the cover on Time Magazine that featured this family with this little girl, this little boy, a husband, a mother that documented how the mother died because the HMO inappropriately denied care. Maybe he does not live in that world. Maybe he does not read Time Magazine.

I thought to myself, maybe he does not read The Washington Post. Most people in Washington do, especially former Members, but maybe he does not. Maybe he did not see the cover story in the Washington Post about this young lady who was hiking 40 miles west of here, fell off a cliff, broke her arm, her pelvis, stunned, fractured her skull, laying there at the bottom of the cliff. Her boyfriend phones in the air flight. They take her to the emergency room. She is treated, and then the HMO does not pay her bill because she did not phone ahead for prior authorization. I thought to myself, what world does this man live in?

I thought to myself, maybe this former Member of Congress has not been watching any of the debates on the floor of Congress. Maybe he has not been following the Patients' Bill of Rights, the debate that we had. Maybe he did not bother to watch the debate we had on the floor when sitting right in that chair was this little boy a few years afterwards. This little boy when he was about 6 had a high fever one night, like about 104 or 105, so his mother phones the HMO, she is told to take him to this one hospital, the only one that is authorized, about 70 miles away, he has a cardiac arrest on the way, he ends up with gangrene in both hands and both feet, and this is what happens when you have gangrene in both hands and both feet. They have to be amputated. I thought, maybe that man had not watched our debate here on the floor. What world is he living in?

But I will tell my colleagues this: this little boy who, when he came to the floor for that debate, was now about 6 or 7, pulls on his leg prostheses with his arm stumps. But do my colleagues know what? This little boy is real; and if he had a finger, Madam Speaker, and we could prick it, he

would bleed. And if he had a hand, some day he would be able to caress the cheek of the woman that he loves, and maybe he would be able to play basketball. But do my colleagues know what? According to this pundit, this former Member of Congress sitting on this panel, after all, there is not anyone being injured by HMOs; it is just baloney.

□ 2115

Madam Speaker, I beg to differ. People come up to me all the time here in Washington and back home in Iowa. They tell me about stories like this, how it is affecting them or their family.

Just a few days ago, about a 48-year-old woman came up to me. She had had a mastectomy for cancer. She had been going through chemotherapy. Her physician had recommended that she have an important test to see whether the tumor had returned. Her HMO denied it. She came up to me in tears in Des Moines, Iowa. She battled that HMO through an internal review and finally they said yes. Then, when she was going to go for her test, they pulled the rug from underneath her and they said no.

She said, Greg, I had to do something I have never done before. I had to ask my husband to carry on for me on this fight, because that HMO has just worn me out. I asked my husband to carry on this fight because I didn't have the energy. I don't have the energy anymore to fight that HMO.

Do Members know what? If that woman dies because she has not gotten her test, what is the HMO out? Nothing, because she is dead. That is not fair and that is not justice. I beg the pardon of that pundit who was on that panel, that man who I like but who does not seem to understand or has been insulated in some way from what has gone on everywhere else in this country.

Why do Members think the biggest line in the movie *As Good as It Gets* was when Helen Hunt tells Jack Nicholson, "You know, that HMO is just preventing my son with asthma from getting the care that he needs." Then she went into a long string of expletives.

My wife and I were in the theater that night. We saw something we had never seen before: People stood up and clapped. What world is that man living in?

Well, Mr. Speaker, Members on both sides of the aisle in both Houses who have been fighting for 5 or 6 years now to get a strong Patients' Bill of Rights passed, they will not give up, because we know that this is affecting millions of people every day on decisions that some HMOs are making.

We need to fix that. We need to fix that here in Washington, because this problem was started by Washington. It

was started right here in 1974, when Congress passed a law which took that oversight of insurance plans away from the States, for heaven's sake, where it had been for 200 years, took it away from the States under a bill called the Employee Retirement Income Security Act, ERISA; they took it away from the States and put nothing in its place, and basically gave immunity to health plans, employer health plans, from the consequences of their decisions, an immunity that no other industry in this country has.

Madam Speaker, I sit on the Committee on Commerce. Last year we heard testimony on the tire problem, where tires were blowing out. At last count, there were about 118 people killed from that. Madam Speaker, what do Members think would happen if Congress passed a law that gave legal immunity to tire makers? Why, we would be run out of Washington on a rail.

Yet, we are dealing with today a law that gives an HMO that makes this kind of decision that results in this kind of injury for somebody who gets their insurance from their employer a free ride. It needs to be fixed. It needs to be fixed.

It is a pretty difficult fight. The HMO industry, their business allies, and some in Congress have fought this tooth and nail. They have spent \$100 million at least trying to prevent the Patients' Bill of Rights from actually becoming law.

Our first victory, though, came in 1999 when the House overwhelmingly passed the bipartisan bill that I and my colleague, a conservative Republican, the gentleman from Georgia (Mr. NORWOOD), and a Democrat, the gentleman from Michigan (Mr. DINGELL), wrote. We passed that bill by a vote of 275 to 151 in the face of very stiff HMO industry opposition.

For the last 6 months, the gentleman from Michigan (Mr. DINGELL), the gentleman from Georgia (Mr. NORWOOD), and I rewrote our bill. We negotiated with Senator MCCAIN to bring him into this fight. On February 6, we introduced our bill, H.R. 526, the Bipartisan Patient Protection Act of 2001, and Senators MCCAIN, EDWARDS and KENNEDY introduced a companion bill in the Senate.

Madam Speaker, this bill represents a meaningful bipartisan compromise on patient's rights issues such as scope, who does the bill cover; plan accountability; employer liability.

I want to go into some more detail. My bill, the Ganske-Dingell bill, includes the basic protections that need to be addressed in this debate, such as the right to choose one's own doctor; protections against one's doctor being gagged by HMOs, not being able to tell us the whole story; access to specialists, such as pediatricians and obstetrician-gynecologists; access to emer-

gency care; access to plan information, so we know what is going on in the plan.

My bill covers all 190 million Americans in private insurance, including ERISA plans, non-Federal government plans, and plans in the individual market. The bill addresses the concerns of those who want to protect States' rights by allowing States to demonstrate that their insurance laws are at least substantially equivalent to the new Federal standards, thereby leaving in place equivalent or stronger State laws. States can continue to enforce their patient protection laws under our bill.

Under our bipartisan bill, patients would be assured that doctors can make medical decisions involving the medical care. When a plan denies coverage, a patient would have the ability to pursue an independent review of the plan's decision by a panel of medical experts, independent of the health plan. That decision would be binding on the plan.

Our bill outlines a new compromise on liability, a new compromise on liability that provides for meaningful accountability for injured patients. We took the lead from the Supreme Court in its case *Pegram v. Hedrich*, and addressed the desire of multistate employer plans for uniformity of benefit decisions.

The new bill creates a bifurcated Federal and State liability system. Injured patients can hold health plans accountable in State court for disputes involving the quality of medical care, those involving medical necessity decisions. However, patients who were injured by a plan's administrative non-medical decision to deny benefits or coverage would proceed to Federal court, and additionally, punitive damages are prohibited in State court unless the plan shows a willful or a wanton disregard for patients' rights or safety.

Our bill also addresses other concerns raised by the bill that passed the House in 1999. For instance, our new bill says, "Employers may not be held liable unless they 'directly participate' in a decision to deny benefits that result in injury or death."

Madam Speaker, I have talked to business groups all across the State of Iowa, employers who run small businesses. I asked them, I say, "When you hire an HMO to provide a health plan for your family and for your employees, do you as an employer ever get involved in the medical decision-making?" And they say, "Not on your life. Number one, it is a privacy issue. We do not want to know what is happening to our employees in their private medical life. We do not want them to know what is going on in our family, either. But we do not get involved in that."

Under our bill, Madam Speaker, that employer cannot be held liable. In re-

cent months, the debate on patient protection has focused on whether or not and to what extent we should hold HMOs accountable when they make medical decisions that harm patients, or even cause them to die.

In recent weeks, congressional offices have been inundated, as I am sure the gentlewoman's office has, Madam Speaker, with messages opposing a strong patient protection bill of rights like our Bipartisan Patient Protection Act of 2001.

I feel, Madam Speaker, that our colleagues need to hear the truth about the liability provisions in our bill, and why I have included those liability provisions in our bill.

Madam Speaker, many opponents to liability provisions in patient protection bills such as the Ganske-Dingell bill say, Why do we need them in the first place? Well, the goal of the liability provision is to ensure that patients receive the proper health care when they need it, and that a patient has a right to redress when the plan makes a medical decision to deny a claim for benefits and causes injury or death.

Under current law, as I said, the patient has access to an internal review process. If there is still a dispute upon conclusion of the plan's internal process, the patient may only seek the value of the benefit in Federal court under section 502 of ERISA. There is no provision under current law for consequential damages caused by the failure to provide the benefit, whether or not there was an injury.

Some States, however, have passed provisions that would allow the patient to hold some health plans accountable in State court for failing to provide adequate care.

Madam Speaker, under our new liability provision, when a patient is denied a benefit, he or she will have access to a swift internal review process and a strong independent external review process to help settle disputes, and that, in the vast majority of times, will get the patient appropriate care.

If the patient feels he or she is owed a benefit under the review process, they will have access to existing 502 ERISA remedies in Federal court to seek the benefit, but not other damages. In those rare cases when a patient suffers harm or death as a result of the plan's action, a patient will have access to Federal court under ERISA section 502 if the dispute was a purely administrative contractual decision. In order to prevail and recover limited damages, the patient would need to show that the plan acted negligently in making the decision, and that the decision caused the patient's injury or death.

But, Madam Speaker, if the dispute involves a medically-reviewable decision, the patient will be able to seek redress in State court under applicable State law. Generally, our bill prohibits

punitive damages if the health plan follows the review process and follows the determination of the external review entity.

In our new bifurcated Federal-State liability, this is a significant compromise. It is a significant move from the State cause of action in the original bill that passed the House, the Norwood-Dingell-Ganske bill, in 1999. Our original language did not change the existing remedy in section 502 of ERISA. Rather, it simply clarified that State causes of action were not preempted under section 514.

The business and insurance industry raised concerns that this approach would inhibit their ability to administer a multistate employee health benefit plan.

□ 2130

Madam Speaker, we made the step towards the business community. Our new bill answers that concern by leaving suits involving benefit administration in Federal court under section 502, thereby allowing employers and insurers to have uniformity in administering their health plans across State lines.

The first part of the liability section in our bill adds to that existing Federal remedy under section 502. Under this new Federal cause of action, a plaintiff may seek both economic and non-economic damages. By excluding medically reviewable decisions from the Federal remedy, group health plans will only be subject to liability under section 502 for benefit administrative decisions. That includes decisions such as whether a patient is eligible for coverage, whether a benefit is part of the plan or other purely administrative contract decisions.

Punitive damages are not allowed under the Federal cause of action. A civil assessment can be awarded upon showing clear and convincing evidence that the plan acted in bad faith. That standard carries a high burden of proof and is consistent with State statutes for the award of damages. That standard ensures a health plan will not be subject to these damages for simply making a wrong decision.

The patient would have to show that the plan has demonstrated flagrant disregard for health and safety in order for the plan to be liable. Madam Speaker, before exercising that legal remedy, the patient would have to exhaust both internal and external appeals processes.

If the patient suffers irreparable harm or death prior to completion of the process, the patient or the plan can continue the review process and the court can consider the outcome.

The second part of the liability section in the Ganske-Dingell bill amends ERISA section 514 to allow cause of actions in State court for a denial of a claim for benefits involving a medi-

cally reviewable decision, a medically reviewable decision that causes harm or death to a patient.

In our bill, punitive damages are prohibited in cases where the plan follows the requirements of the appeal processes. That provision protects plans and businesses when they follow the decision of the external review panel.

But I ask, Madam Speaker, if an industry exhibited a willful and wanton disregard for safety, would you grant them immunity? Under current ERISA law, they have it. We simply say in this section that if they exhibit willful and wanton disregard for safety that they would be liable if it results in an injury.

The Ganske-Dingell bill removes the preemption of State law in ERISA 514. That allows injured patients to bring a cause of action in State court for injuries by a medical decision.

That new provision is a significant compromise, because it limits the scope of actions that can be filed in State court to those involving a medically reviewable decision, whereas the bill that we passed here in 1999, the industry said that you could take contractual decisions into State court. We did not think our bill did that, but we were willing to clarify that, and that what is what we have done.

In addition, we think that our current bill's bifurcated liability provision is consistent with the current direction of the courts in interpreting ERISA law.

Recent Supreme Court decisions and the 5th Circuit decision involving Texas' health plan liability law would allow the continued development of State case laws. The health plan liabilities laws that have passed in nine States, Arizona, California, Georgia, Louisiana, Maine, Oklahoma, Tennessee, Texas and Washington, would not be preempted in our new liability provision. It would be under other bills that are currently being developed, and it would have been under past efforts to create an exclusive, and this is important, Madam Speaker, under an exclusive Federal remedy. All of those preempt State law.

Our new bill further clarifies that employers are protected from liability in either Federal or State court, unless they directly participate in a denial that causes death or harm.

Madam Speaker, that "direct participation" standard was developed by the gentleman from Tennessee (Mr. HILLEARY) and later used in the Coburn-Shadegg substitute. The business and the insurance communities said the previous Norwood-Dingell language was too broad because it held employers harmless unless they exercised discretionary authority to make a decision on a particular claim.

In a spirit of bipartisan compromise, we rewrote the section. We moved towards our critics. But what did they

do? They took a step away. They trashed our bill again. Talk about a moving goal post.

In addition to the direct participation protection, our bill specifically lists decisions that are not considered direct participation. Those specific actions include the employer selection of the group health plan, which plan they choose, the health insurance issuer, third-party administrator or other agent, employers are protected in any cost benefit analysis undertaken by the selection of the plan.

They are protected for any participation in the process of creating, continuing, modifying or terminating the plan or any benefit, and they are protected for any participation in the design of any benefit under the plan. There are additional protections for employers who advocate, who advocate on behalf of an employee in the appeals process.

Furthermore, our bill clarifies existing ERISA law to make certain that a group health plan can purchase insurance to cover losses incurred from suits under this title, just as any medical health professional would do when they know that they are responsible for making medical decisions.

Madam Speaker, recently President Bush sent a letter to Congress outlining his principles for patient protection legislation. And while the President's principles were in nature general, I was pleased to note that our bill met almost all of the President's stated goals, and those goals included providing comprehensive patient protections, applying those protections to all Americans. That is a significant improvement over what we saw in the Senate last time, a review process where doctors make medical decisions and patients receive care in a timely fashion and protections for employers, but the President calls for only allowing Federal lawsuits.

Madam Speaker, such an action would preempt State patient protection laws, including those in Texas, and would treat HMOs differently than all other businesses that could hurt people.

Madam Speaker, I do not know how you can move everything into Federal court and then say at the same time that you are preserving State law. How do you stand, Madam Speaker, in two places at the same time?

As with the President's stated goals, our Ganske-Dingell Bipartisan Patient Protection Act provides patient protections for all Americans, as I said. In addition, our bill empowers governors to certify their State's patient protections provisions as being equivalent to the Federal floor through a process similar to the one for participation in the State children's health insurance program, so that States can continue to enforce their own laws for their citizens.

In addition, our bill has every one of the patients' protections listed in the President's statement of principles, emergency room care, OB/GYNs for women, prescription drug coverage, clinical trials, pediatricians, stopping gag clauses, health plan information choices and continuity of care.

Our bill provides for a quick internal, independent external review process modeled after the strong Texas medical care review process, because getting prompt medical care is the goal of our bill. Our bill requires exhaustion of the review process. Only if a patient dies or is irreparably harmed can a family go to court before the review is completed.

Madam Speaker, it has never been clear to me how you can write a provision that says you have to go through an appeals process before you can go to court when the initial decision can result in an injury in a result such as this.

This mother and father did not have a chance to go through an internal or an external appeal process before their little boy had his cardiac arrest en route to the hospital and developed gangrene and had to have both hands and both feet amputated. But under our bill, because he suffered irreparable harm, that HMO would be accountable, and it should be accountable.

Anyone who tries to pass a law that gives a free skate to a health plan on a case like this I would say is ignoring the scales of justice.

Madam Speaker, I look forward to working with President Bush and my colleagues to ensure swift passage of the Patient Protection Act so that the President can sign into law patient protection legislation as he so frequently talked about during his Presidential campaign.

The HMO industry has made a lot of allegations. One of the things that they have talked about is that employers would be subject to a multitude of frivolous lawsuits. We have already spoken a lot about that.

As I have said, our bill would allow employers to be liable only, only if they have entered into the decision-making.

Another HMO allegation is that with a strong appeals process there is no need for legal accountability for managed care. Madam Speaker, who are they kidding?

Look, they have legal accountability in Texas, and they need it. There is a case in Texas where a man was suicidal in the hospital. His doctor said that he needed to stay in the hospital. His HMO said, no, he does not; he can stay if his family wants to pay for it, but we are discharging him. So the family took him home, and that night he drank half a gallon of antifreeze, and he died.

It is important that Texas has that accountability, that legal, that liability

provision. Because the way that their appeals process is supposed to work is that if there is a dispute between the treating doctor and the health plan and it is in a case like this where something bad could happen immediately, then it goes to an expedited review before the HMO can kick out the patient, but the HMO just ignored it.

The HMO just ignored Texas law. And in that situation, that is why you need at the end of the day accountability and liability for a health plan that makes that kind of decision that results in a man going home and drinking half a gallon of antifreeze and dying.

These are real cases. How about a patient who sustained injuries to his neck and spine from a motorcycle accident? After which, he was taken to the hospital. The hospital's physicians recommended immediate surgery, but the health plan refused to certify. The surgery had to be canceled. Soon afterwards, the insurer did agree to pay, but by then the patient was paralyzed.

Are you going to tell me that that patient who is going to spend the rest of his life paralyzed does not have his right to a day in court because he did not have the time to go through an external appeals process?

□ 2145

How about the patient who was admitted to the emergency room of his community hospital complaining of paralysis and numbness of his extremities. The treating emergency room physician concluded that the gravity of the patient's neurological condition necessitated his immediate transfer to an academic hospital and made the arrangements. The health plan denied the authorization and recommended others.

By the time the physician was able to have the patient transferred, the patient had sustained permanent quadriplegia, could not move both arms or his legs, paralyzed from the neck down.

Now, that patient did not have a chance to go through an internal and an external appeals process, but he sure as heck did suffer irreparable harm. Our bill handles that situation. The opposition's do not.

Another HMO industry allegation is that the Ganske-Dingell bill liability provision would significantly increase the cost of health insurance. The truth of that allegation is blown way out of proportion. They always say, yes, if the cost goes up so much, then so many people are going to lose their insurance.

The Congressional Budget Office scored other liability provisions such as that contained in the Norwood-Dingell bill that passed in the 106th Congress, showing that premiums would rise about 4.1 percent over 5 years. Critics of our bill pounced on that, that

costs were going to skyrocket. But they were wrong.

The part of the bill that costs the most was not the liability provision. It was the section designed to prevent the lawsuits that is common to all of the patient legislation plans that we have seen, and that was the internal and external review sections.

In addition, the HMO industry failed to note that the total CBO projection was spread over 5 years with virtually no cost in the first year and about 1 percent per year after that up to 4 percent total. Now, compare that with the average 7 percent annual increases in recent years by the HMO industry itself.

Opponents have cited an ever-changing and ridiculously wide range of job loss figures for every 1 percent increase in cost. First, the opponents of legal accountability cite the figures that 400,000 individuals would lose their health coverage for every 1 percent increase in premiums. When the GAO challenged that figure, saying that it was based on outdated information and did not account for all the relevant factors, opponents lowered the job loss figure to 300,000 for every 1 percent.

Again, the GAO looked at this and caused opponents to lower their estimate a second time to 200,000. However, none of those predictions have come to pass. For example, between 1988 and 1996 the number of workers offered coverage actually increased despite premium increases each year.

Now, the next allegation I will answer is that consumer support for patient protection evaporates when they learn that it will cost them some additional premiums. This is another one of the HMO industry's distortions. Patients want a real enforceable patient protection Bill of Rights, and they are willing to pay something for it.

A 1998 nationwide survey by Penn, Schoen & Berland showed that 86 percent of the public support a bill that would give patients' health plan legal accountability, access to specialists, emergency services, and point of service coverage. When asked if they would support a bill if their premiums increased between \$1 and \$4 a month, 78 percent supported the bill.

Madam Speaker, the House-passed bill, the Norwood-Dingell-Ganske bill, would have raised insurance premiums an average of 4.1 percent. That would have meant increases in employee premiums of about \$1.36 per month for an individual and \$3.75 a month for a family member.

Finally, I want to dispel the allegation that patients are satisfied with the quality of care being provided by HMOs. HMOs frequently do these surveys of their membership, and they come up with some figure like 80 percent of the enrollees are happy with their care or satisfied. What they fail to point out is that these are all the

healthy people in their plan who are not utilizing the plan.

I mean, does anyone think, when they saw that movie "As Good As It Gets" and saw the response to Helen Hunt's descriptor of her HMO that the public is not aware of this?

A recent public opinion survey found that most Americans believed problems with managed care have not improved, 74 percent. Most think that legislative action is either more urgent or equally as urgent as when this debate began, 88 percent. A 1999 survey of physicians and nurses reported that 72 percent of physicians and 78 percent of nurses believed that managed care has decreased the quality of care for people who are sick.

In addition, Republican pollster, Linda Divall, did a post-election poll right after this last election of issues that the new President and the newly elected Congress should work together on to accomplish for the good of the country. In every group, men, stay-at-home moms, working women, a Patients' Bill of Rights was at the top of the list.

Madam Speaker, the American public wants and deserves a strong patient Bill of Rights now, this year. It is time for us to put on the President's desk a bill like the Ganske-Dingell bill or the McCain-Edwards bill. We need to get it signed into law, Madam Speaker.

Millions of people are having decisions that HMOs are making today. To go back to what I started about at the beginning of the speech, for anyone to say that people are not having any problems with HMO, I would just have to say, what world are they living in?

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ACKERMAN (at the request of Mr. GEPHARDT) for today and the balance of the week on account of illness.

Mr. POMEROY (at the request of Mr. GEPHARDT) for today on account of attending the funeral of a former legislative leader.

Mr. KELLER (at the request of Mr. ARMEY) for today and the balance of the week on account of the hospitalization of his daughter.

Ms. ROS-LEHTINEN (at the request of Mr. ARMEY) for today on account of a death in the family.

Mr. BECERRA (at the request of Mr. GEPHARDT) for today on account of personal business.

SPECIAL ORDERS GRANTED

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

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

Ms. NORTON, for 5 minutes, today.

Mr. FILNER, for 5 minutes, today.

Mr. UNDERWOOD, for 5 minutes, today.

Ms. LEE, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

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

Mr. MORAN of Kansas, for 5 minutes, March 14.

Mr. PAUL, for 5 minutes, today.

Mr. JONES of North Carolina, for 5 minutes, today.

Mr. BILIRAKIS, for 5 minutes, March 20.

Mr. WOLF, for 5 minutes, March 15.

Mr. FOLEY, for 5 minutes, today.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. TANCREDO, for 5 minutes, today.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 9 o'clock and 52 minutes p.m.), the House adjourned until tomorrow, Wednesday, March 14, 2001, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

1191. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule—Prescription Drug Marketing Act of 1987; Prescription Drug Amendments of 1992; Policies, Requirements, and Administrative Procedures; Delay of Effective Date [Docket No. 92N-0297] (RIN: 0905-AC81) received March 7, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1192. A letter from the Special Assistant to the Bureau Chief, Mass Media Bureau, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.622(b), Table of Allotments, Digital Television Broadcast Stations (Rapid City, South Dakota) [MM Docket No. 00-177; RM-9954] received March 6, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1193. A letter from the Special Assistant to the Bureau Chief, Mass Media Bureau, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Woodville and Wells, Texas) [MM Docket No. 00-171; RM-9926] received March 6, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1194. A letter from the Special Assistant to the Bureau Chief, Mass Media Bureau, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Window Rock, Arizona) [MM Docket No. 00-237; RM-10006] received March 6, 2001, pursuant to 5

U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1195. A letter from the Special Assistant to the Bureau Chief, Mass Media Bureau, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.622(b), Table of Allotments, Digital Television Broadcast Stations (Sioux Falls, South Dakota) [MM Docket No. 00-200; RM-9967] received March 6, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1196. A letter from the Special Assistant to the Bureau Chief, Mass Media Bureau, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), FM Table of Allotments, FM Broadcast Stations (Aspen, Colorado) [MM Docket No. 00-215; RM-9994] received March 6, 2001, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

1197. A communication from the President of the United States, transmitting a 6-month periodic report on the national emergency with respect to Iran that was declared in Executive Order 12957 of March 15, 1995, pursuant to 50 U.S.C. 1703(c); (H. Doc. No. 107-50); to the Committee on International Relations and ordered to be printed.

1198. A communication from the President of the United States, transmitting notification that the Iran emergency is to continue in effect beyond March 15, 2001, pursuant to 50 U.S.C. 1622(d); (H. Doc. No. 107-51); to the Committee on International Relations and ordered to be printed.

1199. A letter from the Department of Defense, Defense Security Cooperation Agency, transmitting the listing of all outstanding Letters of Offer to sell any major defense equipment for \$1 million or more; the listing of all Letters of Offer that were accepted, as of December 31, 2000, pursuant to 22 U.S.C. 2776(a); to the Committee on International Relations.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. SENSENBRENNER: Committee on the Judiciary. H.R. 741. A bill to amend the Trademark Act of 1946 to provide for the registration and protection of trademarks used in commerce, in order to carry out provisions of certain international conventions, and for other purposes (Rept. 107-19). Referred to the Committee of the Whole House on the State of the Union.

Mr. TAUZIN: Committee on Energy and Commerce. H.R. 496. A bill to amend the Communications Act of 1934 to promote deployment of advanced services and foster the development of competition for the benefit of consumers in all regions of the Nation by relieving unnecessary burdens on the Nation's two percent local exchange telecommunications carriers, and for other purposes; with an amendment (Rept. 107-20). Referred to the Committee of the Whole House on the State of the Union.

Mr. TAUZIN: Committee on Energy and Commerce. H.R. 725. A bill to establish a toll free number under the Federal Trade Commission to assist consumers in determining if products are American-made (Rept. 107-21). Referred to the Committee of the Whole House on the State of the Union.