

year. We can do that with \$11 billion; and \$11 billion as compared to the \$1.6 trillion tax cut, that is no comparison at all.

There is no reason why we cannot fully fund special education this year. I urge my colleagues to do just that.

WOMEN'S HISTORY MONTH; AND THE HIV/AIDS VIRUS AS IT AFFECTS WOMEN AND CHILDREN

The SPEAKER pro tempore (Mr. GILCHREST). Under a previous order of the House, the gentlewoman from Maryland (Mrs. MORELLA) is recognized for 5 minutes.

Mrs. MORELLA. Mr. Speaker, I am very pleased to be here this afternoon for this important special order to celebrate Women's History Month. I know my colleague, the gentlewoman from Illinois (Mrs. BIGGERT), will be continuing with this special order.

I would like to point out that, as we approach a new century, there is no doubt that women have made great strides in business, the professions and trades and as leaders in government. Society is the richer for it.

Although women have made enormous strides, discrimination in the workplace still exists. So does discrimination in health research and in the delivery of health care or the lack thereof, steadfastly remaining our problem, "a woman's problem." We have to continue to improve the lives of women and children, which ultimately will benefit everyone.

Mr. Speaker, we are going to hear from my colleagues the history of women's health, and I do want to say that women are not little men. I am pleased, with my colleagues many years ago, we celebrated the 10th anniversary of the Office of Research on Women's Health at the National Institutes of Health. Prior to that time, women were not included in clinical trials or protocols.

There was the famous aspirin test with regard to cardiovascular disease. It was done with about 44,000 male medical students. Yet the extrapolation was that this is the way women would be affected by it. Well, there is breast cancer, ovarian cancer, osteoporosis, lupus. We now are beginning to concentrate on research with regard to women and the implications of those diseases and diagnoses and treatments.

But I thought that I would devote my time now to speak about a silent epidemic which is not often spoken about, a kind of silent genocide, if you will, the death and dying that no one is really addressing: those that occur to women and children who carry the HIV virus and represent the growing face of the AIDS epidemic.

We are at a crossroads in the history of the AIDS epidemic. Thanks to dramatic new treatments and improve-

ments in care, the number of AIDS-related deaths has begun to decline. However, while we have made great strides, the crisis has not yet abated. Continued research is needed to provide better, cheaper treatments and eventually a vaccine or a cure.

Remarkable medical advances have done nothing to stem the rise in new infections among adolescents, women, and minority communities. In fact, the well-publicized success of new drug therapies has encouraged some to believe that the epidemic has peaked, making it harder than ever to reinforce the need for prevention among those who are most at risk.

As a result, HIV/AIDS remains a major killer of young people and the leading cause of death for African Americans and Hispanics between the ages of 25 and 44. Across this country and around the world, AIDS is rapidly becoming a woman's epidemic. Women constitute the fastest-growing group of those newly infected with HIV in the United States. Worldwide, almost half of the 14,000 adults infected daily with HIV, for example, in 1998, were women, of whom nine out of the 10 live in developing countries.

In Africa, teenage girls have infection rates five to six times that of teenage boys, both because they are more biologically vulnerable to infection and because older men often take advantage of young women's social and economic powerlessness.

Statistics of the economic, social and personal devastation of HIV and AIDS in subSaharan Africa are staggering. Now 22.3 million of the 33.6 million people with AIDS worldwide reside in Africa, and 3.8 million of the 5.6 million new HIV infections occurred in Africa in 1999. By the year 2010, 40 million children will be orphaned by HIV and AIDS. Children are being infected with HIV and AIDS, many through maternal-fetal transmission.

Biologically and socially, women are more vulnerable to HIV and AIDS than men. Many STDs and HIV are transmitted more easily from a man to a woman and are more likely to remain undetected in women, resulting in delayed diagnosis and treatment and even more severe complications. Yet, more than 20 years into the AIDS crisis and at a time when the incidence of HIV and STDs is reaching epidemic proportions, the only public health advice to women about preventing HIV and other STDs is to be monogamous or to use condoms.

I have been working very hard and we have had many results with regard to the development of microbicides to help to prevent the spread of HIV and other STDs and have legislation to do so. So much more needs to be done.

I do hope that all of us in Congress will look at what we can do to stop that hemorrhage of HIV and AIDS, especially in women and young people.

WOMEN'S HISTORY MONTH AND WOMEN'S HEALTH ISSUES

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. MILLENDER-MCDONALD) is recognized for 5 minutes.

Ms. MILLENDER-MCDONALD. Mr. Speaker, as we know, we proclaimed Women's History Month last week; and the topic last week was on education, women and education. Today I rise to speak about women's health issues as part of our Women's History Month series.

Since the earliest days of the Nation, women have acted as the health gatekeepers of their families. In recent years, however, it has become clear that women have significant health concerns of their own, such as breast and cervical cancer, heart disease and osteoporosis.

But women's health issues are much more than individual diseases. It is a lifespan issue, beginning with the delivery of high-quality prenatal care services to when a woman lives out of her final days, hopefully after a full, productive and healthy life.

Sadly, though, Mr. Speaker, the health of the Nation's women is severely jeopardized by preventable illnesses, inadequate access to health care, poverty, domestic violence, chronic disease and a host of other factors.

Currently, nearly 18 percent of non-elderly women have no health insurance. Even worse, more than 30 percent of Hispanic women and nearly 25 percent of African American women between the ages of 19 and 24 have no health insurance.

Cardiovascular disease is the number one cause of death among all women. Lung cancer is the number one cancer killer of women, and its rate continues to increase. Battering is the number one cause of injury to women today, causing more injuries that require medical treatment than car crashes and mugging combined.

In addition, one study found that 25 to 45 percent of battered women experience physical violence while they are pregnant.

Much shame, Mr. Speaker. So much work needs to be done to help alleviate these startling statistics. There needs to be increased funding and more major national projects for women's health research, services and education. There is also a need to be a focus on women's health through the life cycle: adolescent, reproductive, middle-aged and older women, since their needs are different.

Last but not least, Mr. Speaker, we need to work to eliminate barriers to health care services for underserved women.

Mr. Speaker, much work has been done in the last couple of decades concerning research and education about

women's health, but there is much more to be done. When the President spoke at the State of the Union, he mentioned an increase in funding for NIH. I was pleased to hear that, because I felt that we can have an increase in funding for cervical cancer, breast cancer, lung cancer, heart disease and diabetes. So Mr. Speaker, I will be introducing a bill suggesting the increased funding for those areas.

I would also call on the President to provide the health insurance for those over 10 million children who are without health insurance and the women who are without health insurance.

So, as we celebrate Women's History Month, let us be mindful of the need for increased funding for women's health.

WOMEN'S HISTORY MONTH

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

Mrs. BIGGERT. Mr. Speaker, as the Republican co-chair of the Congressional Women's Caucus, I am very excited about what the 107th Congress promises for women, particularly in the area of health care. There have been great strides made in recent years in the area of women's health care, and I think that since the month of March is Women's History Month, I would like to thank my colleagues from the Congressional Women's Caucus who are taking the time to come down here this afternoon out of their busy schedules to discuss women's health issues.

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I think that a number of women will be discussing issues from eating disorders, breast cancer, and long-term care; and these are issues that affect all women, no matter their age, race, nationality or sexual orientation. I commend my colleagues for continually taking the lead on these important issues and look forward to continuing our work in the 107th Congress.

Mr. Speaker, I would like to, I think, look at one issue, but I cannot begin really without talking about that, for the first time in history, that the House Subcommittee on Health will be chaired by a woman, the gentlewoman from Connecticut (Mrs. JOHNSON), our friend and colleague. That is very fitting when the issues that affect women have become so dramatic.

One of the issues that I would like to address in the area of women's health care that I care deeply about is long-term care. I think long-term care has long been called the sleeping giant of all U.S. social problems. This issue affects all Americans but particularly women for three reasons: Number 1 is we live longer; number 2, we are the ones who take care of our aging relatives; and, number 3, we are much

more likely to retire with little or no pension savings. That makes us especially vulnerable to the high costs of long-term care.

The Census Bureau estimates that there are currently 34 million Americans aged 65 and older living in the United States. By 2030, that number is expected to more than double to 70 million, some 20 percent of the population. The fact that Americans are living longer and living more healthy lifestyles than at any time before should be celebrated. However, it does present a challenging public policy problem.

These numbers demonstrate the demand for long-term home or institutional care is going to grow exponentially. Neither the public nor the private sectors have adequately planned to meet the overwhelming future demand for long-term care services.

We must increase the public's awareness of the importance of preparing for long-term needs, as well as encourage individuals to save for their future, to invest in IRAs and mutual funds and to purchase long-term care insurance policies.

In addition, we must encourage employers to provide long-term care coverage as part of their employee benefit plans.

This is why I plan to reintroduce legislation that I introduced in the 106th Congress, the Live Long and Prosper Act, Long-term Care and Retirement Enhancement to address this issue.

There are several ways my bill addresses the problem facing long-term care.

First, my bill provides an above-the-line deduction, starting with 60 percent in 2002 and rising to 100 percent in 2006, for the cost of long-term care insurance premiums paid during a given year for the taxpayer, his or her spouse and dependents.

These provisions will make long-term care insurance more financially accessible, particularly for the young and those with lower incomes.

Second, my bill gives employers the option of providing long-term care insurance coverage as part of a cafeteria plan, in which employees are able to choose from a variety of medical care or other benefits, or flexible spending account, in which employees set aside pretax dollars for copayments or deductibles on insurance plans.

Third, my bill provides an additional personal exemption to the estimated 7 million Americans who provide custodial care to an elderly relative living in their home. The exemption was valued at \$2,750 in 1999 and should help to alleviate some of the financial burdens involved with caring for a loved one at home.

These are just a few of the provisions of the bill, and they represent a market-based solution to an ever-growing demand for long-term care services and financing. But the financial incentives

alone will not be enough to address the potential long-term care delivery and financial crisis.

Mr. Speaker, I urge all of my colleagues to take a look at that bill and to look at the women's health issues that are involved therein.

MANAGED CARE REFORM— MEDICAL NECESSITY

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

Mr. GREEN of Texas. Mr. Speaker, I would like to congratulate my colleagues, the congressional women, for making this effort today for special orders for women's health care. I would like to associate myself with their remarks, because everything they have said on a bipartisan basis is so important.

The reason I am here today, Mr. Speaker, is that the third time I have talked about the importance of managed care reform, real managed care reform, 3, 4 weeks ago I talked about the independent review process, and the accountability 2 weeks ago, and today I want to talk about medical necessity.

Every patient in America deserves to have important medical decisions made by his or her doctor, not by an HMO bureaucrat. Unfortunately, managed care personnel, who often have no substantial medical training, are determining what is medically necessary.

This practice endangers patients, threatens the sanctity of the doctor-patient relationship and undermines the foundation of our health care system.

Most managed care companies base treatment decisions on professional standards of medical necessity. But we often hear cases where HMO plans write their own standards into their contracts, and these standards often conflict with the patients' needs.

The case of Jones v. Kodak clearly demonstrates how a clever insurance health plan can keep patients from getting the needed medical care.

Mrs. Jones' employer provided health insurance coverage for in-patient substance abuse treatment. Unfortunately, the health plan determined that she did not qualify for this treatment. Even after an independent reviewer stated that the plan's criteria was too rigid and did not allow for tailoring of case management, Mrs. Jones was still denied treatment.

To add insult to injury, the courts stated that the health plan did not have to disclose its protocols or its rationale for making that decision.

A health plan's decision does not have to be based on sound medical science, standard practices or even basic logic. In fact, a health plan can