and reducing our tax burden on families, they would clearly side with reducing taxes and reducing the national debt.

Mr. Speaker, this budget will probably fall to a similar fate as last year's budget, which was a vote of 422 opposed and 2 in favor of the President's budget.

Mr. Speaker, I urge this administration to come back to the table, save these surpluses for paying down our national debt, shoring up Social Security and giving people their money back if they still overpay their taxes, instead of using it to spend $1.3 trillion on the creation of 84 new Federal Government programs.

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HEALTH CARE REFORM STILL MAJOR ISSUE FOR AMERICANS

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

Mr. GANSKE. Mr. Speaker, I am going to probably not take all of my allotted hour tonight, probably about half an hour or so. Any colleagues that may be following should have notice of that.

This weekend in Parade Magazine, February 6, 2000, on page 15, there is a cartoon. I do not have it blown up like I have made charts of many cartoons in the past as I have spoken here on patient protection legislation, so let me describe what this cartoon shows. It shows a doctor sitting at his desk holding a sheet of paper. There is a patient, a man, sitting in the chair in front of the desk. The doctor is saying, ''Your HMO won't cover any illness contracted in the 20th century.''

Well, Mr. Speaker, it is a truism that in order for something to be funny, in order for there to be a joke to be effective or a cartoon to be effective, the public has to understand what the punch line is and what the issue is. And the issue, of course, is that HMOs have not treated many people around this country fairly. They have come up with rules and regulations in byzantine and bizarre ways to deny necessary, medically necessary care for their patients. So of course when we see a cartoon like this where a physician is telling a patient sitting in front of him, ''Your HMO won't cover any illness contracted in the 20th century,'' it fits right in with what we think of as an unfairness of treatment by HMOs, along with the turn of the century, the new millennium.

I think that this cartoon and the jokes that we will frequently hear about HMOs indicate where the public is in their opinion on health maintenance organizations and whether they get treated fairly and whether, in fact, they think Congress ought to finally get something done to pass patient protection legislation.

I have been coming to the well of this House of Representatives for 5 years now. I started out with a bill that I had called the Patient Right to Know Act that would have banned gag clauses in HMO contracts that prevent physicians from telling patients all of their treatment options. I mean, the situation is such that some HMOs have tried to prevent physicians from telling a patient all of their treatment options because one of them might be an expensive one; and they have required physicians, for instance, to phone the HMO to get an authorization before they can even tell a patient what the treatment options are.

Before I came to Congress, I was a physician. It would be like me examining a lady with a lump in her breast knowing that there are three treatment options, and then because this HMO has this gag clause in a contract, having to excuse myself, go out into the hallway, get on the telephone and ask some bureaucrat at some HMO whether I can tell the patient about all three of her treatment options. I mean this issue has been here in Congress for too long, and the public feels that way.

I have here a survey done by Kaiser Family Foundation, the Harvard School of Public Health called National Survey on Health Care and the 2000 Elections, January 19, 2000. They were surveying a number of issues, but they said on patient rights, more consensus emerged on the issue of patient rights, even though, after nearly 2 years of debate, voters have decided that a Patients' Bill of Rights could increase the cost of their premiums. We will talk about that later, because the costs have been greatly overestimated by the managed care industry, and there are several studies that show that a cost increase in a person's premiums would be very modest, probably in the range of several dollars per month. That would then mean that one's insurance would actually mean something if one got sick.

Mr. Speaker, to go on of what the findings in the survey showed, about two-thirds of registered voters, of health care voters, because they divided this up into voters that were concerned about different issues, and education and health care, by the way, were way at the top of this survey, two-thirds of registered voters think health insurance premiums for people like them would go up if patient protections were enacted, but very few think their premiums would go up very much. And I say to my colleagues, they are right.

Now, 72 percent of registered voters favor patients' rights legislation versus only 17 percent that oppose it. In contrast to other health issues, there is more consensus between Democratic and Republican registered voters on patients' rights with 75 percent of Democratic registered voters and 68 percent, more than two-thirds, more than two out of three of Republican registered voters favoring patient protection legislation.

It goes on to say, one reason there may be greater consensus on patient rights is that many registered voters view patient protection legislation as a plus for them personally. Mr. Speaker, 45 percent say that it would make them better off, and only 7 percent say it would make them worse off. Mr. Speaker, 37 percent say they would not be much affected, but among health care voters, 52 percent say it would make them better off. As in past Kaiser-Harvard surveys, support for patients' rights does not fall when people believe health insurance premiums will go up.

Well, Mr. Speaker, maybe it is because the presidential candidates have looked at this issue; they are being asked about it constantly. Maybe it is because some of them have been told by all of the people that they are talking to around the country right now about what they feel about this. Maybe it is because they have looked at the polls. I do not know exactly why. But, Mr. Speaker, all of our major presidential candidates, whether we are talking about Democrats or Republicans, believe that we ought to pass patient protection legislation.

Let me just read to my colleagues a few of the statements from both Democrats and Republicans on this issue. One of these people will be our next President. Here is what Bill Bradley says: ''Health care decisions should be made by doctors and their patients, not an insurance company bureaucrat. A patient who feels that an HMO has denied needed care should have the right to an independent appeals process and should have the right to sue if harmed by an HMO decision. I support the Patients' Bill of Rights and I would push for a consumer right to know which would ensure that HMOs reveal important details of a plan that affect the care you receive.'' Democrat running for President.

How about a Republican running for President. Here is what the Republican who won the New Hampshire primary, Senator JOHN MCCAIN, has said on HMO reform. When asked whether patients should have the right to sue, the most contentious issue, Senator MCCAIN says yes. ''Once a patient has exhausted all options to obtain appropriate medical care that has been denied by an HMO, including going through a free and fair internal and external appeals process, that patient should have the right to seek redress in the courts. The right to sue should be limited to actual economic damages and capped noneconomic damages under terms that do not foster frivolous lawsuits.''

What does AL GORE, Vice President GORE, say about this? He says, ''I believe that we must pass a strong enforceable Patients' Bill of Rights to ensure that people insured by HMOs get the health care they need when they need it. For many people, the decisions HMOs make can be the difference between life and death, and no one should

have to worry about an HMO at a time when they are worried about their immediate survival. That is why I am calling for improved patient care by granting patients the right to an independent appeal when they are denied treatment, access to specialists, guaranteed coverage of emergency room treatment and the right to hold health maintenance organizations accountable for their actions.''

What does Governor George Bush say on the issue of patient protections? By the way, I believe all of these statements are in an AARP infomercial that has been broadcast around the country. Here is what Governor Bush says about this. Governor Bush has a lot of experience on this, because several years ago Texas passed a strong patient protection piece of legislation, several pieces of legislation, and here is what he says: ''I believe patients need access to a speedy and impartial forum to resolve disputes over health care coverage. Texas has a law that gives patients the right to seek legal action if they have been harmed. I allowed it to become law because we have a strong independent review process and other protections designed to encourage quick out-of-court resolutions instead of costly litigation. The process is working in Texas,'' Governor Bush says. He goes on and says, ''I would support similar protections at the Federal level, provided they do not supercede the patient protection laws Texas and many other States already have on the books.''

Well, Mr. Speaker, the bill that was passed here in the House last year, the bipartisan consensus Managed Care Reform Act of 1999 written by the gentleman from Georgia (Mr. NORWOOD), the gentleman from Michigan (Mr. DINGELL), and myself, passing this House by a wide vote margin of 275 to 151, was modeled after the Texas law. Last week I gave a similar Special Order on this and I pointed out the many, many similarities between the bill that passed the House and what is currently in place in Texas.

As Governor Bush has told me personally and spoken on this vigorously, that bill is working. The HMO industry did not fall apart when it was passed. There were 30 HMOs in Texas; today there are over 50. There has not been a plethora of lawsuits; in fact, there have only been about four filed. We know that the filings are an accurate index of how well that law is working, because Texas has a 2-year state of limitation on filings.

So if there were any cases out there, we would know about it. But there have not been because they have a dispute resolution mechanism, an independent review panel, and because the HMOs know that if they do not follow the law, they are going to be liable; and of those cases, those few cases that have been filed in Texas, most of them have been because the HMOs did not follow the law. So they should be liable, especially if a patient goes out and commits suicide, as is one of those cases, because the HMO made an incorrect determination on medical necessity. They did not follow the Texas law.

I could go on and talk about others who have endorsed this, but I think for a minute we ought to talk about what is going on here in Congress now. Because a bill passed the Senate a year or so ago and as I mentioned, we passed a strong bipartisan bill here in the House of Representatives a couple of months ago. So once we have a bill that passes the Senate and a bill that passes the House, if they are not the same, then they go to what is called a conference committee.

Unfortunately, it looks as if the conference committee has been stacked against coming up with a strong, good piece of legislation that could have the support of the House of Representatives that was already voted on for strong legislation, and a bill that could get the President's signature. Why do I say that? Well, let me read from the Daily Monitor, Congressional Quarterly from Friday, February 4. It says, ''Although the House in October passed the patients' right portion of the overall managed care bill by 275 to 151 with 68 Republicans voting yes, House Speaker DENNIS HASTERT stacked the conference committee with foes of that measure. Only one Republican on that conference committee from the House voted for the bill that passed the House with 275 votes, and that one person voted for all of the alternatives.''

Well, I think that we are seeing here a foot-dragging, at least an appearance from naming of the conferees that there really is not a commitment to take the clear message that the House gave in that vote, but also in several motions to instruct for our conferees to stand up for the bill that passed this House of Representatives with a strong bipartisan vote.

□ 2030

I mean, that vote only came after we had to jump over many hurdles during that debate that were put up by the opponents to passing patient protection legislation.

I think that House Republicans in particular fear that Democrats could leverage voter anger over this perceived foot-dragging in an election year. So we are seeing statements now coming out about, well, we should get a bill out, bring it back to the House, bring it back to the Senate from the conference.

But I just have a bit of recommendation for my Republican colleagues. If they bring back a bill that is not a strong bill, that plays games with the fine details, that does not address the issue of medical necessity, which continues to allow for Federal employee plans, the ability for HMOs to define ''medical necessity'' in any way that they want to, a bill that does not have a strong enforcement provision to make sure that HMOs follow the rules, then it cannot pass. That conference report cannot pass the House. We cannot get it to the President, and we are at a stalemate.

The gentleman from Georgia (Mr. NORWOOD) who wrote that bill, along with me on the Republican side, we stand ready and available to our leadership to help in terms of getting a strong piece of legislation that is a real piece of patient protection legislation to the House. I have made that offer to the Speaker on several occasions. We will continue to work to try to make sure that a bill that comes out of conference, that comes to the floor of the House, is worthy of the name ''patient protection legislation.''

Let me just point out a couple of areas where we could see some real problems. The patient protection bill was married to a bill on patient access to deal with the uninsured. I certainly think that we ought to deal with trying to decrease the number of uninsured. I think there are components in that access bill which could gain bipartisan support. I mean, moving to 100 percent deductibility for health insurance for individuals and making that effective January 1, 2000, would be one of those things that would get broad bipartisan support. I am certainly in favor of that.

Currently this year individuals who purchase their health insurance only have a 60 percent deduction, as versus a business getting a 100 percent deduction for health insurance for their employees. I do not think that is fair. We ought to fix that now. That is one of the items that could be the basis for a bipartisan agreement on access.

But there are some provisions in that other bill that got married to the patient protection bill which are really big problems. Let me give an example. The Congressional Budget Office just did a study on what are called association health plans, or are otherwise known as multiple employer welfare association plans, MEWAs; AHAs, MEWAs, all these acronyms.

What these are, an association health plan is where an organization, for instance, could offer a health plan to its members and be included under Federal law but be absolved from State insurance regulation for the health plan.

Multiple employer welfare associations are basically the same thing. Years ago when Congress first passed the Employee Retirement Income Security Act, ERISA, the piece of legislation which pulled insurance oversight away from the States and basically left nothing in its place for quality control, which is why we have this problem with HMOs as offered by employers today, years ago when that bill passed there was a loose definition of ''associations.''

We saw a number of bogus associations offer health plans. They were undercapitalized. In some cases they were simply fraudulent. They went bankrupt. People ran away with the profits, and a whole bunch of people,

hundreds of thousands of people, were left without insurance.

So Congress came back in the early 1980s and they tightened up the definition. They said, you can only offer an employer plan if you are a labor union or if you are an employer; an employer, not a grouping of employers or associations. Congress had to learn the hard way. A lot of people had to learn the hard way what the problem was. But some people now want to expand that definition again. I think the Clinton administration is correct on this, that it is not a good idea.

Let me give some reasons why. There was a study of association health plans just done by the Congressional Budget Office. This analysis by the CBO found that most small employers and workers would actually pay higher premiums if a preemption from State law for association health plans is brought back in this conference report, if it were enacted.

The report reveals that association health plans would save costs by skimming the healthy from the existing State-regulated small group market, thus making coverage more expensive for those who are left in that State coverage; i.e., the sick.

Specifically, this Congressional Budget Office report said that association health plans would not significantly reduce the number of uninsured. This is why a lot of people have said, well, we need to do association health plans that would decrease the number of uninsured.

But the Congressional Budget Office has looked at this and said, not so. Contrary to opponents' claims that AHPs would cover up to 8.5 million uninsured, the Congressional Budget Office estimated that coverage would only increase by 330,000 individuals, but also noted that the overall number of individuals insured would be lower, ''Because some of those who gained coverage through association health plans would have otherwise obtained coverage in the individual market.''

Then the CBO goes on to say, ''Four in five workers would be worse off under association health plans and health marts.'' According to the CBO report, 20 million employees and dependents of small employers would experience a rate increase under association health plans, while only 4.6 million would see a rate reduction.

Those do not sound like particularly great numbers to me. We are going to reduce the rate for about 4.5 million, but we are going to increase the premiums for 20 million. Does that make sense? Is that something we should be putting into a bill where we are trying to reduce the number of uninsured?

The CBO says, ''In addition, 10,000 of the sickest individuals would lose coverage if association health plans were enacted. Association health plans would save money primarily by cherry-picking.'' What does that mean? The CBO estimated that nearly two-thirds of the cost savings for association health plans would result from attracting healthier members from the existing insurance pool.

I come from one of the largest insurance centers in the United States, Des Moines, Iowa. I think it has more insurance companies than Hartford, Connecticut. I can say something about how insurance works. It works by making sure there is a large enough pool of the insured so we can spread out the risk, the cost of the risk.

But what association health plans would do is they would pull the healthy out of that larger market. Sure, the premiums might be lower for that group, but it would leave a sicker group behind. As the CBO said, we could see many, many people lose their insurance, because with that sicker pool, now the cost of premiums would go up dramatically. We would have a smaller pool but a sicker pool. Therefore, in order to not go bankrupt, the insurers who are covering that group that is left behind would have to raise their premiums a lot.

The CBO report goes on, ''Association health plans would eliminate benefits to cut costs.'' Think about that, association health plans would eliminate benefits to cut costs. Contrary to proponents claims that association health plans could offer generous benefits while lowering insurance costs, the Congressional Budget Office found that dropping State-mandated benefits would be the second major method the AHPs would use to reduce costs; i.e., cherry-picking. But they estimated that ''One-third of cost savings would come from eliminating benefits.''

Then the CBO went on to say, ''Association health plans would not reduce overhead costs. Contrary to claims that association health plans could reduce overhead by 30 percent, CBO assumed that cost savings arising from the group purchasing feature of association health plans and health marts would be negligible.'' They found no substantial evidence that joining a purchasing coop produced lower insurance costs for firms.

The CBO correctly points out that States with aggressive insurance reforms would see the most damage. The CBO report indicates that States with strict insurance reforms like Massachusetts, New Jersey, New York, would be most attractive to the association health plans.

The report concludes that ''In States with more tightly compressed premiums, where the most cross-subsidization occurs, low-cost firms would face the greatest potential difference in price between traditional and association health mart plans.''

I mean, Mr. Speaker, if my colleagues want a full report, the report called ''Increasing Small Firm Health Insurance Coverage Through Association Health Plans and Health Marts,'' the study that I am talking about, it is available on the CBO web site www.cbo.gov, g-o-v.

I would recommend to my colleagues that they look this up, because it is very possible that we could see a conference report come back that has this provision in it that could actually increase the number of uninsured, rather than decrease it, and could undermine State efforts at providing insurance coverage.

I have here a letter from my Governor. I just got this. This is from Governor Vilsack of the State of Iowa. It is addressed to all of the Iowa Congressmen and Senators.

''Gentlemen, it has come to my attention that conferees from the U.S. House of Representatives and the U.S. Senate will soon meet to consider the patient protection bills passed by each Chamber last year. I have been advised that the House version of this legislation contains provisions that would exempt multiple employer welfare arrangements and association health plans from a variety of State laws.''

Okay, that is the provision that was in the access bill that was married to the patient protection bill. So it does not deal as expressly with patient protection, but it is being folded into the patient protection legislation.

The Governor goes on to say, ''I would like to express my concern about these proposals for the following reasons.'' And I happen to believe, Mr. Speaker, that just about every Governor in this country will write a similar letter to us, whether they are Republican or Democrat, on this issue.

My Governor says, ''It is my view that the MEWA AHP provisions would render State small employer health insurance reforms unworkable by allowing groups to opt in and out of State regulation based on their medical needs. Furthermore, these provisions would lead to a siphoning of healthy workers from the State-regulated health insurance market, which would then become a dumping ground for high-cost groups. As premiums rise for those remaining in the State-regulated market, more small firms would drop out of health insurance coverage, and the number of uninsured in our State and across the Nation would increase. This seems contrary to efforts in our State to try to reduce the number of uninsured individuals.''

Governor Vilsack goes on: ''The legislation could also mean a Federal takeover of health insurance regulation by preempting traditional State regulatory authority.'' Let me just repeat this: ''The legislation could also mean a Federal takeover of health insurance regulation by preempting traditional State regulatory authority.''

I am a Republican. How many times have I heard my colleagues from my side of the aisle say, ''Hey, we need to devolve power back to the States.'' The States are the places where we ought to be doing insurance.

□ 2045

There is a bill that passed a long time ago called the McCarran-Ferguson Act, which basically says that insurance regulation should be done at the State level.

I would like to know how many of my Republican colleagues want to repeal the McCarran-Ferguson Act and take it over by the Federal Government. I am one of those Republicans who believe that the role of the Federal Government should be limited; that we should not be taking this over.

This was part of the original problem with the ERISA bill. We exempted oversight by the States and so we have had a lot of abuses.

The governor goes on to say, States would be powerless to enforce their insurance rules with regard to these federally-licensed health plans or to resolve problems for their residents quickly. Moreover, States could no longer move quickly to prevent the insolvency of a failing association health plan, or seize assets to assure payment of enrollees and local health care providers.

We are getting right back to what I was talking about before. Past experience has shown that some of these plans have gone insolvent.

Traditionally the State takes over to make sure that people are not left uninsured, but if they are under the Federal purview, what happens to those people whose plans then go bankrupt?

Governor Vilsack then goes on, ''For all those reasons,'' listen to this my colleagues, ''for all those reasons, the National Governors' Association, the Republican Governors' Association, the National Conference of State Legislatures, the National Association of Insurance Commissioners have opposed those provisions.''

My governor finishes by saying, ''I add my voice to theirs in asking you to reconsider such provisions so that we do not run the risk of increasing the number of uninsured in Iowa and in the country.

''Furthermore, I think it is important and necessary for States to be able to continue to regulate this important industry as we have successfully done for a number of years.

''Iowa has a reputation for a balanced regulation and it would be difficult to maintain that balance with these federally-imposed requirements. Sincerely, Tom Vilsack, governor of Iowa.''

I would again reiterate that I think that most of the Members are going to receive a similarly worded letter from their governors, whether they be Democrat or Republican, on this issue. So if the conference bill comes back to us with these association health plans or these multiple employer welfare associations, people need to think very, very seriously, if they are really serious about decreasing the number of uninsured, whether they can support a bill that would have this type of provision in it.

Now, another issue that is going to be very important is on the issue of medical necessity and who at the end gets to determine medical necessity. The bill that we passed here in the House basically says that that independent peer panel, if there is a dispute and a patient has gone through the internal appeals process through their HMO and is unhappy with the decision by the HMO, that the patient can take that denial to an independent peer panel, a group of doctors not paid for by the HMO or a part of the HMO, and get an independent review.

The House version says that unless you have a specific exclusion of coverage in the contract, for instance the HMO contract that you have specifically says we will not provide a bone marrow transplant, that unless there is a specific exclusion then that independent panel determines the medical necessity of the treatment, not the health plan.

Unfortunately, we have a situation with the bill from the other side of the capitol that does not address this issue. In fact, it is worse than the status quo. It would basically say that HMOs can define medical care in any way they want to.

What does that mean? Well, under Federal law now you have some HMOs that are saying we define medical necessity as the cheapest, least expensive care, quote/unquote.

For all of us who are concerned about health care costs, you might initially think, well, what would be wrong with that? Well, I can say what is wrong with that. As a plastic and reconstructive surgeon, I took care of a lot of kids who had cleft lips and palates. They were born with a deformity in the roof of their mouth, a big hole in the roof of their mouth, and they cannot eat without food coming out of their nose and they cannot speak properly.

The commonly accepted, standard treatment for that is a surgical repair to bring those tissues together and to recreate a roof of the mouth so that, A, they do not have food going up into their nose and coming out and, B, so that they can learn to speak properly or have the best chance to do that.

Under this definition that some HMOs have come up with, i.e., the cheapest, least expensive care, they could justify the treatment for a child with that birth defect as a piece of plastic, like an upper denture; we are just going to give him an upper denture to put in the roof of his mouth. That is a travesty, but that could exactly happen and people have lost their lives on the basis of decisions that HMOs have made on medical necessity where they have ignored their physician's advice and denied needed treatment.

Many times I have stood up here and told the story about a little boy from Atlanta, Georgia, who when he was 6 months old, in the middle of the night, had a temperature of 104, and his mother thought he needed to go to the emergency room and she phoned a 1–800 number for an HMO and was told, well, you can only take him to one emergency room. That is all we are going to authorize.

It was 60-some miles away. After they had passed several hospitals where the little boy could have been treated, he had an arrest, a cardiac arrest, before he got to the hospital. Partly as a result of that loss of circulation to his hands and his feet, he developed gangrene in both hands and both feet and they both had to be amputated.

That HMO made a medical decision and said we will let you go to the emergency room but only this one a long way away. If you go to any other ones, you have to pay for it yourself, and mom and dad were not medical professionals; they did not know how sick little Jimmy was until his eyes rolled back in his head and he stopped breathing en route to the hospital.

In my opinion, when an HMO makes a medical decision like that they ought to be legally responsible for that. Under current Federal law, if it is a health plan that you get through your employer, in that type of situation the health plan would be liable only for the costs of the amputations. I do not think that is justice.

Furthermore, none of the leading contenders for President, whether they be Republican or Democrat, think that that is justice. How can one defend a health maintenance organization that is making life and death decisions and say they should have a legal shield from their medical malpractice?

As a physician, I have never argued that physicians should be free of liability from their malpractice and I do not know of any physicians who do that, who make that argument. That is why we carry malpractice insurance. I do not know of any auto maker that has a legal liability shield like that. I do not know of any of our airplane manufacturers or airlines. I do not know of any business in this country that has that kind of legal immunity and, yet, because of a 25-year-old Federal law, HMOs that deny medically necessary care and provide that insurance through an employer they are not liable. They are only liable for the cost of care denied, and if the patient has died then they are liable for nothing.

I just don't think that that is fair. I do not think that one can justify that. I think one would be laughed out of any room in this country. That is why I find it very hard to understand how some colleagues of mine can oppose restoring responsibility.

I am a Republican. I have argued on this floor many times that people ought to be responsible for their actions. Many of my Republican colleagues have made the same comments. If somebody is a cocaine or a drug dealer, they ought to be liable for that. They ought to spend time in jail. If somebody commits murder, I bet an awful lot of my Republican colleagues would say if they are guilty of first degree murder they should get the death penalty. I know that when we passed the welfare reform bill, our thoughts were that if one is an able- bodied person and they get help and they have a period of time to get some training,

then it is their responsibility to get a job.

Responsibility has been a big word on this Republican side. But where do I see that type of responsibility being applied to HMOs? If it is not addressed by the conference committee, then that bill will not pass this House and we will end up with a big goose egg, a big zero, for addressing this major problem.

I started out this talk by saying I have been working on this for 4 years, 5 years. So has the gentleman from Georgia (Mr. Norwood), and many others on both the Republican and the Democratic sides. In the meantime, a lot of patients have been denied necessary care; a lot of patients who have ended up like that little boy from Atlanta, Georgia, with some significant deficits, if not loss of their life, as has been outlined by major magazines such as Time Magazine on feature cover stories.

It really is time, Mr. Speaker, that we addressed this issue; that we do not load up a conference report with bad ideas; that we take the bill that passed this House, a bill that could be signed into law tomorrow by President Clinton, a bill that tomorrow could be giving people around this country a fair shake by their HMOs. We ought to do it soon, and I sincerely hope that the motives of the members of the conference committee are to actually accomplish a piece of legislation and are not simply a face-saving measure because they know that this is an election year and the public is demanding that Congress take action.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. MCNULTY (at the request of Mr. GEPHARDT) for today on account of illness.

Ms. MILLENDER-MCDONALD (at the request of Mr. GEPHARDT) for today and the balance of the week on account of illness.

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. METCALF) to revise and extend their remarks and include extraneous material:)

Ms. ROS-LEHTINEN, for 5 minutes, today and February 9.

Mr. HERGER, for 5 minutes, today.

Mr. COLLINS, for 5 minutes, today.

Mr. BURTON of Indiana, for 5 minutes, February 9 and 15.

Mr. SCARBOROUGH, for 5 minutes, February 9 and 10.

Mr. METCALF, for 5 minutes, today.

Mr. SOUDER, for 5 minutes, today.

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

Mr. NORWOOD, for 5 minutes, today and February 14 and 15.

Mr. NETHERCUTT, for 5 minutes, February 9.

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

Mr. RYAN of Wisconsin, for 5 minutes, today.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 1503. An Act to amend the Ethics in Government Act of 1978 (5 U.S.C. App.) to extend the authorization of appropriations for the Office of Government Ethics through fiscal year 2003; to the Committee on Government Reform; in addition to the Committee on the Judiciary for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADJOURNMENT

Mr. GANSKE. Mr. Speaker, pursuant to House Resolution 418, I move that the House do now adjourn in memory of the late Hon. Carl B. Albert.

The motion was agreed to; accordingly (at 8 o'clock and 57 minutes p.m.), pursuant to House Resolution 418, the House adjourned until tomorrow, Wednesday, February 9, 2000, at 10 a.m., in memory of the late Hon. Carl B. Albert.

EXECUTIVE COMMUNICATIONS, ETC.

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

6062. A communication from the President of the United States, transmitting a request to make available appropriations for the Federal Emergency Management Agency's Disaster relief program; (H. Doc. No. 106–193); to the Committee on Appropriations and ordered to be printed.

6063. A letter from the Under Secretary, Personnel and Readiness, Department of Defense, transmitting the final report on the results of the Department of Defense demonstration project for uniform funding of morale, welfare, and recreation (MWR) activities; to the Committee on Armed Services.

6064. A letter from the Director, Office of Federal Housing Enterprise Oversight, transmitting the Office's final rule—Rules of Practice and Procedure (RIN: 2550–AA04) received January 5, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Banking and Financial Services.

6065. A letter from the Director, Regulations Policy and Management Staff, FDA, Department of Health and Human Services, transmitting the Department's final rule—Indirect Food Additives: Adjuvants, Production Aids and Sanitizers [Docket No. 98F–1201] received January 5, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6066. A letter from the Director, Regulations Policy and Management, FDA, Department of Health and Human Services, transmitting the Department's final rule—Indirect Food Additives: Adjuvants, Production Aids, and Sanitizers [Docket No. 99F–1421] received January 5, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6067. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Title V Operating Permit Deferrals for Area Sources: National Emission Standards for Hazardous Air Pollutants (NESHAP) for Chromium Emissions from Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks; Ethylene Oxide Commercial Sterilization and Fumigation Operations; Perchloroethylene Dry Cleaning Facilities; Halogenated Solvent Cleaning Machines; and Secondary Lead Smelting [AD-FRL–6508–7] (RIN: 2060–A158) received December 10, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6068. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Revisions to Guidelines for the Storage and Collection of Residential, Commercial, and Institutional Solid Waste [FRL–6505–6] (RIN: 2050–AE66) received December 10, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6069. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—OMB Approvals Under the Paperwork Reduction Act; Technical Amendment [FRL–6505–8] received December 10, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6070. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Implementation Plans and Part 70 Operating Permits Program; State of Missouri [MO 090–1090; 6508–4] received December 10, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6071. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Implementation Plan; Indiana Volatile Organic Compound Rules [IN114–1a; FRL–6500–9] received December 10, 1999, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6072. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Implementation Plans; California State Implementation Plan Revision, South Coast Air Quality Management District, El Dorado County Air Pollution Control District, Yolo-Solano Air Quality Management District, and Ventura County Air Pollution Control District [CA 031–0202; FRL–6508–5] received January 7, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6073. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Implementation Plans; California State Implementation Plan Revision, Kern County Air Pollution Control District [CA172–0203, FRL–6513–9] received January 7, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

6074. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Air Quality Implementation Plans; Maryland; Control of VOCs from Paper, Fabric, Vinyl, and Other Plastic Parts Coating [MD090–3041; FRL–6506–9] received January 7, 2000, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.