179TH ANNIVERSARY OF GREEK INDEPENDENCE

Mr. PALLONE. Mr. Speaker, lastly today, if I could just spend a few minutes, I noticed that, earlier this evening, a number of my colleagues on both sides of the aisle made statements on the floor addressing the 179th anniversary of Greek independence. I wanted tonight, before I conclude, to just congratulate the people of Greece and, of course, Americans of Greek descent, on this 179th anniversary, which occurred over the weekend, last Saturday, March 25.

I think we all know that, throughout our country's history, Greece has been one of our greatest allies, joining the U.S. in defending and promoting democracy in the direst of circumstances.

The Greek people have also made invaluable contributions to the betterment of American's society. Following traditions established by their descendants, Greek-Americans have reached the highest levels of achievement in education, business, the arts, politics, and athletics, to name just a few; and American culture has been enriched as a result.

But I wanted to take the opportunity this evening on the anniversary of Greek independence today to discuss an issue that is of great concern to Greece and to Greek Americans, and that is the proposed $4 billion of attack helicopters to Turkey by the United States and the current negotiations and the Cyprus issue.

Let me just say in unambiguous terms that the U.S. should not go forward with the sale of attack helicopters to Turkey for a variety of reasons. Chief among them are the continued human rights abuses by the Turkish military against the Kurdish people in Turkey and the potential to undermine the recent thaw in relations that has occurred between Turkey and Greece.

Human rights abuses by the Turkish military against the Kurdish minority in Turkey have been well documented, not only by human rights organizations, but by the U.S. State Department as well. These abuses are systematic and in and of themselves are reason enough not to go forward with the sale of U.S. attack helicopters to Ankara.

In 1998, the administration outlined the progress in human rights Turkey would need to make in order for such a sale to go through. Those conditions have certainly not been met, Mr. Speaker. To ignore this fact would be to violate our country's own deeply held beliefs about human rights. This, however, is hardly the only reason why the sale should not go forward.

Moving forward with the sale would undermine our long-standing policy to help ease tensions in the region between Greece and Turkey. The U.S. credibility with Greece will surely suffer if we urge them to take steps to reduce tensions with Turkey at the same time we sell Ankara attack helicopters. Such a sale could hardly come at a worse time. There had been a thaw in relations between Greece and Turkey sparked by the humanitarian gestures each country made to the other following earthquakes that rocked both nations last year. The helicopter sale could well be seen by Greece as a destabilizing step and upset the fragile progress that has been made in this regard.

□ 2100

Similarly, the proposed sale could have an equally harmful effect on the new round of peace negotiations in Cyprus. With these talks recently underway, it would be particularly foolish to sell Turkey high-tech offensive U.S. weapon systems.

The United States' long-standing policy has been that any settlement of the Cyprus problem be consistent with innumerous U.N. resolutions that have been passed on the Cyprus situation over the last two and a half decades. As my colleagues know, that is also the position of the Cyprus government. In other words, the U.S. position on Cyprus is consistent with that of Cyprus and Greece themselves. Moving forward with the helicopter sale would undercut the U.S.'s long-standing position on this issue and it simply should not happen.

The United States, Mr. Speaker, should be doing exactly the opposite of what the administration is proposing. Rather than cozying up to the Turkish military through the sale of attack helicopters, the U.S. should be publicly and privately coming down hard on Ankara and the Turkish military. In unequivocal language, and through both private and public mediums, the U.S. should communicate to Turkey, and particularly to the Turkish military, that there will be immediate and severe consequences in U.S.-Turkish relations if progress is not made on the Cyprus issue.

I do not have to repeat, but I will say that the illegal occupation of Cyprus is now almost 26 years old. Those of us who have worked on this issue in the House of Representatives must take advantage of every opportunity to reaffirm our commitment to bringing freedom and independence back to the Cypriot people. Indeed, reaffirming our commitment to standing firm with the Greek people, just as they have stood with us throughout our history, is a very appropriate thing to do on Greek Independence Day. Indeed, this is precisely why I wanted to talk about the issues I have raised today.

I can think of no better occasion to speak against the proposal to sell American attack helicopters to Turkey than on Greek Independence Day, a day when we should be honoring Greece for its commitment to our shared values and celebrating ways to strengthen the ties between our two countries, not weaken them. To that end, Mr. Speaker, I once again congratulate Greek Americans and the people of Greece on the 179th anniversary of Greek independence.

I urge all my colleagues to do the same and to join me in opposing the sale of attack helicopters to Turkey, in working for a just resolution to the Cyprus problem, and in working to strengthen the special bond that the United States and Greece have shared for so long.

IMPORTANT ISSUE FACING HOUSE-SENATE CONFERENCE ON HEALTH CARE REFORM

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

Mr. GANSKE. Mr. Speaker, tonight I am going to talk about a very important issue before the House-Senate conference committee on HMO reform. I think it is important for the members of the conference to understand the issue of medical necessity. It is probably one of the two or three most important issues that they will have to deal with.

I think it would be useful for those members to know about testimony that occurred before the Committee on Commerce on May 30, 1996. We have been working on this for many years now. On that day, a small nervous woman testified before the House Committee on Commerce. Her testimony was buried in the fourth panel at the end of a very long day about the abuses of managed health care. The reporters had gone, the television cameras had packed up, most of the original crowd had dispersed.

Mr. Speaker, she should have been the first witness that day, not one of the last. She told about the choices that managed care companies and self-insured plans are making every day when they determine ''medical necessity.'' Her name was Linda Peno. She had been a claims reviewer for several HMOs. Here is her story.

''I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred. I was rewarded for this. It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do what was asked, expected of me, I exemplified the good company employee. I saved a half a million dollars.''

Now, Mr. Speaker, as she spoke, a hush came over the room. The representatives of the trade associations who were still there averted their eyes. The audience shifted uncomfortably in their seats, both gripped by and alarmed by her story. Her voice became husky, and I could see tears in her eyes. Her anguish over harming patients as a managed care reviewer had caused this woman to come forth and to bear her soul. She continued:

''Since that day, I have lived with this act and many others eating into my heart and soul. The primary ethical norm is do no harm. I did worse, I caused death. Instead of using a clumsy bloody weapon, I used the simplest, cleanest of tools: my words. This man died because I denied him a necessary operation to save his heart.'' She continued: ''I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for the moment. When any moral qualms arose, I was to remember, 'I am not denying care, I am only denying payment.' ''

Well, by this time, Mr. Speaker, the trade association representatives were staring at the floor. The Congressmen who had spoken on behalf of the HMOs were distinctly uncomfortable. And the staff, several of whom subsequently became representatives of HMO trade associations, were thanking God that this witness came at the end of the day when all the press had left.

Linda Peno's testimony continued: ''At the time, this helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize that action. I accept my responsibility now for that man's death, as well as for the immeasurable pain and suffering many other decisions of mine caused.''

She then listed the many ways managed care plans deny care to patients, but she emphasized one particular issue, the right to decide what care is medically necessary. She said, ''There is one last activity that I think deserves a special place on this list, and this is what I call the 'smart bomb of cost containment,' and that is medical necessities denials. Even when medical criteria is used, it is rarely developed in any kind of standard, traditional, clinical process. It rarely is standardized across the field. The criteria is rarely available for prior review by the physicians or members of the plan.'' She continued: ''We have enough experience from history to demonstrate the consequences of secretive unregulated systems that go awry.''

Well, Mr. Speaker, after exposing her own transgressions, she closed by urging everyone in the room to examine their own conscience. ''One can only wonder how much pain, suffering and death will we have before we have the courage to change our course. Personally, I have decided that even one death is too much for me.''

The room was stone quiet. The chairman mumbled thank you. Linda Peno could have rationalized her decisions, as so many do ''Well, I was just working within guidelines''; or ''I was just following orders''; or ''We just have to save resources''; or ''Well, this isn't about treatment, it's really just about benefits.'' But this brave woman refused to continue that denial, and she will do penance for her sins for the rest of her life by exposing the dirty little secret of HMOs determining medical necessity.

My colleagues on the conference committee, please keep in mind the fact that no amount of procedural protection or schemes of external review can help patients if insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage. As this HMO reviewer so poignantly observed, ''Insurers now make treatment decisions by determining what goods and services they will deliver, they will pay for.''

The difference between clinical decisions about medically necessary care and decisions about insurance coverage are especially blurred. Because all but the wealthy rely on insurance, the power of insurers to determine coverage gives them the power to dictate professional standards of care. And make no mistake, along with the question of health plan liability, the determination of who should decide when health care is medically necessary is the key issue in patient protection legislation.

Now, Mr. Speaker, contrary to the claims of HMOs that this is some new concept, for over 200 years most private insurers and third-party payers have viewed as medically necessary those products or services provided in accordance with what is called prevailing standards of medical practice. And the courts have been sensitive to the fact that insurers have a conflict of interest because they stand to gain financially from denying care. So the courts have used ''clinically derived professional standards of care'' to reverse insurers' attempts to deviate from those standards.

This is why it is so important that managed care reform legislation include an independent appeals panel with no financial interest in the outcome, a fair review process utilizing clinical standards of care guaranties that the decision of the review board is made without regard to the financial interest of either the HMO or the doctor. On the other hand, if the review board has to use the health plan's definition of medical necessity, there is no such guaranty.

In response to the growing body of case law, and their own need to demonstrate profitability to shareholders, insurers are now writing contracts that threaten even this minimal level of consumer protection. They are writing contracts in which standards of medical necessity are not only separated from standards of good practice but are also essentially not subject to review.

Let me give my colleagues one example out of many of a health plan's definition of medically necessary services. ''Medical necessity means the shortest, least expensive or least intense level of treatment, care or service rendered or supply provided as determined by us.'' Well, Mr. Speaker, contracts like this demonstrate that some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not the patient's medical needs.

Now, on the surface some may say, well, what is wrong with the least expensive treatment? Well, let me show my colleagues just one example out of thousands I could cite. Before coming to Congress, I was a reconstructive surgeon. I treated children with cleft palates, like this baby. Clinical standards of care would determine that the best treatment is surgical correction. But under this HMO's definition of medical necessity, the shortest, least expensive and least intense level of treatment, that HMO could limit coverage for correction of this child's roof of his mouth to a piece of plastic to fill the hole.

□ 2115

After all, a piece of plastic would be cheaper. However, instead of condemning this child to a lifetime of using a messy prosthesis, the proper treatment, reconstruction using the child's own tissue, would give this child the best chance at normal speech and a normal life.

But now, Mr. Speaker, now the conference between the House bill, the Norwood-Dingell-Ganske bill, a good strong bill, and the Senate bill, which is a joke, could paradoxically give insurers legislative changes that displace even case law.

Last year, the patient protection legislation that passed the Senate would grant insurers the explicit power to define ''medical necessity'' without regard to current standards of medical practice. This would be accomplished by allowing insurers to classify as medically unnecessary any procedures not specifically found to be necessary by the insurer's own technical review panel.

The Senate bill would even give insurers the power to determine what evidence would be relevant in evaluating claims for coverage and would permit insurers to classify some coverage decisions as exempt from administrative review.

Now, I know that many of our colleagues in the Senate who supported that Senate bill had no idea about the implications of the ''medical necessity'' provisions in that bill.

Specifically, insurers now want to move away from clinical standards of care applied to particular patients to standard linking medical necessity to what are called population studies or to ''guidelines'' by companies like Milliman & Robertson.

Now, on the surface this may seem to be scientific and rational. However, as a former medical reviewer myself who worked with many insurers, large and small, let me explain why I think it is critical that we stick with ''medical necessity'' as defined by clinical standard of care and that we not bind the independent review panel to the plan's own guidelines.

In the version of patient protection that passed this House, if there is a dispute on a denial of coverage and it goes

through internal review and then goes to external review and to that independent external review panel, unless there is a specific exclusion of coverage, that independent panel can use in its decision many things.

It can use medical literature, the patient's own history, recommendation of specialists, NIH statements. It can even use the plan's own guidelines. But, critically, it is not bound by the plan's own guidelines. That is the provision that we should have come out of conference.

Here are some reasons why we should not rely solely on what are called outcome studies or guidelines. First, sole reliance on broad standards from generalized evidence is not good medical practice. Second, there are practical limits to designing studies that can answer all clinical questions. And third, most of the studies are not of sufficient scientific quality to justify overruling clinical judgment.

Let me explain these points further. And for anyone who wants more depth on this discussion, I refer them to an article by Rosenbaum, et al., in the January 21, 1999, edition of the New England Journal of Medicine.

First, while it may sound counterintuitive, it is not good medicine to solely use outcomes-based studies or guidelines for ''medical necessity,'' even when the science is rigorous. Why? Because the choice of the outcome is inherently value laden.

The medical reviewer for the HMO is likely, as shown by the above-mentioned contract, to consider cost the essential value. But I would ask my colleagues, what about quality?

Now, as a surgeon, I treated many patients with broken fingers simply by reducing the fracture, putting the bones back in the right place, and splinting the finger. And for most patients, that would restore adequate function. But what about the musician, what about the piano player or the guitar player who needs a better range of motion? In that case, surgery might be necessary. So I would ask, which outcome should be the basis for the decision about insurance coverage, playing the piano or routine functioning?

My point is this: taking care of patients involves much variation. Definitions of ''medical necessity'' have to be flexible enough to take into account the needs of each patient. One-size-fits-all outcomes make irrelevant the doctor's knowledge of the individual patient; and that is bad medicine, period.

Second, there are practical limitations on basing medical necessity on ''generalized evidence'' or on ''guidelines,'' particularly as applied by HMOs.

Much of medicine is as a result of collective experience, and many basic medical treatments have not been studied rigorously. Furthermore, aside from a handful of procedures that are not explicitly covered, most care is not specifically defined in health plans because the numbers of procedures and the circumstances of their applications are infinite.

In addition, by their very nature, many controlled clinical trial study treatments are in isolation, whereas physicians need to know the benefits of one type of treatment over another in a particular patient.

Prospective randomized comparison studies, on the other hand, are expensive. Given the enormous number of procedures and individual circumstances, if coverage is limited to only those that have scientifically sound generalized outcomes, care could be denied for almost all conditions.

Mr. Speaker, come to think of it, maybe that is why HMOs are so keen to get away from prevailing standard of care.

Third, the validity of HMO guidelines and how they are used is open to question. Medical directors of HMOs were asked to rank the sources of information they used to make medical decisions. Industry guidelines, generated by trade associations, or printed by companies like Milliman & Robertson ranked ahead of information from national experts, government documents, NIH consensus conferences.

The most highly respected source, medical journals, was used in less than 60 percent of the time. Industry guidelines are frequently done, as I mentioned, by a company by the name of Milliman & Robertson. This company is a strategy shop for the HMO industry. This is the same firm that championed drive-through deliveries and outpatient mastectomies. Many times these practice guidelines are not grounded in science but are cookbook recipes derived by actuaries to reduce health care costs.

Here are two examples of the errors of their guidelines. Remember their drive-through deliveries? Remember their outpatient mastectomies? Well, the National Cancer Institute released in June a study that found that women receiving outpatient mastectomies face significantly higher risks of being rehospitalized and have a higher risk of surgery-related complications like infections or blood clots that could be life threatening.

A 1997 study published in the Journal of the American Medical Association showed that babies discharged within a day of birth faced increased risks of developing jaundice, dehydration, and dangerous infections. So much for those specific guidelines from Milliman & Robertson.

The objectivity of medical decision-making requires that the results of studies be open to peer review. Yet, much of the decision-making by HMOs is based on unpublished ''proprietary'' and unexamined methods and data. Such secrets and potentially biased guidelines simply cannot be called scientific.

Now, this is not to say that outcomes-based studies do not make up a part of how clinical standards of care are determined, because they do. But we are all familiar with the ephemeral nature of new ''scientific,'' quotes, studies such as those based on the dangers of Alar.

There has recently been a report in one of the medical journals about discharging patients from a hospital within a day or two of having a heart attack. There was also an editorial in that medical journal expressing severe reservations about that and expressly saying that HMOs and managed care companies should not use this article out of context as an excuse to send heart attack patients home within a day or two of being in the hospital.

Clinical standards of care do take into account valid and replicable studies in the peer-reviewed literature, as well as the results of professional consensus conferences, practice guidelines based on government funded studies, and even guidelines prepared by insurers that have been determined to be free of conflict of interest.

These are all things that can be considered by that independent review panel in the House bill. But they are not bound by any one of them. But most importantly, they also include the patient's individual health and medical information and the clinical judgment of the treating physician.

Well, Mr. Speaker, Congress should pass legislation defining the standard of medical necessity. Because first, the Employee Retirement Income Security Act, ERISA, shields plans from the consequences of most decisions about medical necessity. Second, under ERISA, patients generally can only recover the value of the benefits denied. And third, even this limited remedy is being eroded by insurance contracts that give insurers the authority to make decisions about medical necessity based on questionable evidence.

To ensure those protections, Congress should provide patients with a speedy external review of all coverage disputes, not merely those that insurers decide are subject to review. It is time for Congress to defuse what former HMO reviewer Linda Peno described as the smart bomb of HMOs.

Now, Mr. Speaker, for years Milliman & Robertson, the company that has created the practice guidelines of HMOs, has operated sort of in the background. I think it is time, Mr. Speaker, to shine a spotlight on Milleman & Robertson's role in setting HMO standards that are the smart bombs that this HMO reviewer described as giving her authority to kill a man.

The operating practices of this company are just becoming public because of fact-finding in a lawsuit that has been filed by two pediatricians, two pediatric doctors, Tom Cleary and Bill Riley, who charged that the company falsely credited them as coauthors of a book on pediatric utilization review.

These pediatricians are filing suit not just because they did not write the sections that Milliman & Robertson credits to them, but to get the book off the market because they consider the

length-of-stay criteria in the book to be dangerous.

Dr. Cleary said, ''Milliman & Robertson limits hospital stays for serious diseases such as meningitis, that is infection of the covering of the brain and the spinal cord, and endocarditis, infection of the heart, to just 3 days, when it should be more than a week.''

''I want Milliman & Robertson to get out of the business of writing pediatric guidelines,'' says Dr. Cleary. But the company is not budging. It has not recalled thousands of copies of those pediatric guidelines or agreed to stop publishing so-called guidelines.

□ 2130

Let me remind you what Milliman & Robertson is. That is the company that proposed one-day limits on delivery of babies. That caused such an outcry that Congress and 41 States passed laws overriding drive-through deliveries. Milliman & Robertson's guidelines are cited in class action HMO liability suits against Humana in Florida and Prudential in New York.

Why is it that Milliman & Robertson continues to write the type of rules that Linda Peno cried out against? Mr. Speaker, because they make so much money from the denial of care business. Milliman & Robertson's book Pediatric Health Status Improvement and Management, 1998, is part of a nine-volume set on utilization management. The company has sold more than 20,000 copies, charging $500 for each book, while at the same time selling consultant services to help HMOs implement those guidelines. Its list of customers includes Anthems, Incorporated; Signa Health Care; Kaiser Foundation Health Plan; and Pacific Care among many others. Although Milliman & Robertson says its length of stay limits are ''best case scenarios,'' its own promotional material maintains that they apply to fully 80 percent of hospitalized patients younger than the age of 65.

Plus, a company official told the AMA Council on Scientific Affairs that 90 percent of admissions exceed guidelines. I ask you, how can a guideline described as a best case be exceeded 90 percent of the time? The suit brought by Drs. Cleary and Riley gives us a rare glimpse into how Milliman & Robertson creates its utilization review guidelines.

The company produced the pediatrics book with the paid help of Dr. Robert Yetman, who Milliman & Robertson officials found when he agreed with their assertion that lead screenings are unnecessary in Texas because few homes have lead paint. In his deposition, Dr. Yetman said that he did not ask for written authorization from 17 department colleagues listed as coauthors. Getting written authorization is customary in academic studies. But Dr. Cleary says he never orally agreed, either, to join the study and his only relation to it was to review one page of material for Dr. Yetman. Dr. Cleary said he first learned his name was being used as an author 10 months after publication, and he immediately asked Yetman to remove it. Dr. Yetman said the company refused until a new edition was printed. Well, this made Dr. Cleary furious. He was the only infectious disease subspecialist listed as an author for that volume on pediatric utilization management, and he felt that everyone would assume that he wrote the hospitalization limits for his subspecialty, such as endocarditis and meningitis, even though he never reviewed them.

Dr. Riley had similar concerns as the only pediatric endocrinologist listed. Dr. Riley says that the lengths of stay in his field are ''so clearly outside any reasonable approach to the standard of care as to be wholly reckless.'' Dr. Riley says that he fears that Milliman & Robertson's length of stay goals, quote-unquote, are fast becoming standards of care, and I would add that this is exactly the problem with these HMO guidelines. They are not peer reviewed nor published in respected medical journals.

Dr. John Neff, the chair of the Hospital Care Committee of the American Academy of Pediatrics, calls guidelines such as Milliman & Robertson's ''opinions.'' Dr. Neff points out that patients' conditions vary tremendously and that there are not enough reliable scientific studies on lengths of stay for specific conditions to form objective standards. Exactly what I was speaking about earlier in this talk.

I know that most physicians have no idea what is in this company's guidelines. They may even be cited as authors without their consent, as happened to Dr. Riley and Dr. Cleary. Here is a brief list of conditions with Milliman & Robertson's length of stay compared to commonly accepted standards for length of stay. For diabetic ketoacidosis, that is a child who goes into coma from diabetes. Milliman & Robertson says that child only needs to stay in the hospital 1 day. One day. Mr. Speaker, the standard would be 3 days. But Milliman & Robertson can save that HMO 2 days in the hospital.

How about osteomyelitis. That is an infection in the bone. Milliman & Robertson says this child can only stay in the hospital 2 days. Mr. Speaker, do you know what the standard of care is for a child with a serious bone infection? Four to 6 weeks in the hospital on IV antibiotics. But Milliman & Robertson says 2 days is enough.

Neonatal sepsis. That is a child who has an infection that is in the blood. Milliman & Robertson's guidelines say only need to keep that child in the hospital 3 days. The standard of care is 2 to 3 weeks. How would you feel if you were a parent with a child with these diseases? How about bacterial meningitis. That is a bacterial infection of the meninges. This is the covering of the brain, the covering of the spinal cord. According to the Milliman & Robertson standards, you only need to keep that child in the hospital for 3 days. Anything over that, that is excessive. What is the standard? Ten to 14 days. How about an infection in your heart, an infection in the heart of a baby? Milliman & Robertson says only need to keep that child in the hospital 3 days. What is the standard of care? One week.

Mr. Speaker, these ''guidelines'' are not just scary. In my opinion, they represent malpractice. I urge my colleagues to consider this information when they deal with medical necessity in conference. And, my friends, the next time you read a Milliman & Robertson study on HMOs supplied to you by the American Association of Health Plans, or the Health Insurance Association of America, just remember that this company is a flak for the industry and has a significant financial tie to HMOs and health plans. Do you think they are going to say anything that critical of HMOs when their business depends on HMOs?

Mr. Speaker, the conferees on patient protection in the conference committee should adopt the language of the House bill. Any less on this medical necessity issue will not be worth the paper that it is printed on. I hope that my colleagues on the conference committee are listening, because the lives of a lot of people in this country are depending on how you write that section.

ILLEGAL NARCOTICS

The SPEAKER pro tempore (Mr. OSE). Under the Speaker's announced policy of January 6, 1999, the gentleman from Florida (Mr. MICA) is recognized for 60 minutes.

Mr. MICA. Mr. Speaker, I come before the House on the floor tonight to talk once again in regard to what I consider the most serious and devastating social issue facing not only the Congress but our entire Nation and that is the problem of illegal narcotics and the heavy toll they have taken on our Nation, particularly our young people.

Tonight, I am going to try to cover some material some may have covered before but I think in light of tomorrow's action on the proposal for an emergency supplemental in the House of Representatives, I will focus some on the story of how we got to an emergency situation, particularly as it involves narcotics and the primary source of those narcotics, Colombia, the country of Colombia, and the South American region where those illegal narcotics are coming from.

Then I hope to also touch upon some of my committee work for the benefit of my colleagues and the American people as chair of the Criminal Justice, Drug Policy and Human Resources Subcommittee. I know the hour is late. Many folks are tired. But I hope that they will listen tonight, because the message I have is an important one for the Congress and again for the American people. It will really detail some