The President of Texas A&M, Dr. Bowen, has said that he will consider this report and decide in the next 2 months whether to allow the bonfire tradition to continue or not, and if he makes a decision on whether to allow it, under what conditions it will be allowed.

This report makes no recommendations about whether it should or should not be continued, but it does point out some things that I think are worth highlighting.

Number one, one obviously need to have structural integrity of the bonfire. One needs to have professional oversight of the bonfire.

Under the tradition of Texas A&M, it has all been done by students. There was no written design, it had to be certified as having structural integrity. Each bonfire student leadership looked at what was been done the year before and then decided what to do this year.

I cannot tell Dr. Bowen what to do, but I would certainly think that some of the things he has got to consider is have a design that is actually on paper that has been certified as structurally sound by professional engineering groups, and then make sure that there is oversight to see that the design is actually implemented.

Speaking only for myself, I can certainly understand if Dr. Bowen decided not to allow the bonfire to continue, but I would hope that he will allow the tradition to continue under very restrictive and overseeing regulations.

PATIENT'S BILL OF RIGHTS CONFERENCE

The SPEAKER pro tempore (Mr. SHERWOOD). 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, on last Friday, in the USA Today, I could not help but notice on the front page an article. It was called ''HMOs Take Spiritual Approach.'' It is written by Julie Appleby. It starts out by saying ''Health plans, buffeted in recent years by their no-frills approach to medical care, are pushing ever further into alternative medicine, hoping to find low cost ways to boost patient satisfaction. Need help understanding the meaning of life? No problem. A Denver-based HMO offers spiritual counseling, six visits at $10 a pop. Fearing surgery? Blue Shield of California unveils a new prescription today, free audio cassettes for patients aimed at harnessing their imaginations to promote healing.''

Mr. Speaker, when I read this and when I also read about some of the abuses by some of the HMOs, I think patients will need some of this spiritual healing to get over some of the ways that they have been treated by HMOs.

I want to talk tonight for a little while about where we stand in conference with the patient protection legislation that passed the House and the Senate. My information on how the conference is going is from my sources on the Republican side. There have been reports that the conference is making some progress. Maybe a month ago, there was reported progress on emergency care provisions and also on a couple other smaller items that should be relatively noncontroversial. It should be pointed out that there has been no legislative language divulged from any of these earlier ''agreements in principle.''

But about a week or 2 ago, there was a report that there was progress being made on one of the most important parts of the bill, which is, how does one handle disputes between care that is requested by a patient and care denied by the HMO. In both the bill in the House and in the Senate, when there is a dispute on a denial of care by the HMO, a patient could take that to an external appeals panel.

The reports in the press seem to indicate that progress was made and that there was some sort of agreement between the Republicans and the Democrats in the House-Senate conference on this point. Well, I am sorry to inform my colleagues on both sides of the aisle here in the House that these reports have been vastly overplayed.

As a result of that, President Clinton asked for a meeting for this Thursday of conferees down at the White House to try to spur on progress on the patient's rights. But let me just point out some of the problems, these are from my Republican sources, on how there is not agreement on some of the fundamental aspects of the external appeals process.

For instance, there is not agreement on the standard for determining whether cases are eligible for review. Mr. Speaker, this is sort of fundamental. One has to know what kind of cases can go to review, and this has not been decided.

In determining whether a case is eligible for review, the independent reviewer should not be limited by a plan's definition or interpretations where they involve applications of medical judgment. This is what is in the House. This is the provision in the House where we say that the independent panel can make a determination on medical necessity that is not bound by the plan's own guidelines. They can be considered. The plan's guidelines can be considered, but the independent panel is not bound by those.

Also, it has not been decided in terms of protection, such as the independent panel determining medical necessity disputes on coverage or benefit determinations, and which of those are not subject to review.

Now, in the House bill, we say that if there is an explicit denial of coverage in the contract, then regardless of whether the patient needs that medical procedure or not, that independent panel cannot tell the HMO to give the care.

For instance, the HMO could write a contract saying we do not cover liver transplants. A patient could come along, maybe medically need a liver transplant, but under the House bill, the independent panel cannot tell the HMO to give that, because there is an explicit exclusion of coverage. But aside from that, this crucial question has not been decided in the conference.

Other things related to external review have not been decided in the conference. For instance, there has not been a decision on what to do with existing State laws that deal with external appeal systems. Now, in my opinion, the independent review should have the authority to direct the health plan to provide the care. That is what we passed here in the House with a vote of 275 to 151.

□ 1845

We said, okay, if there is a denial of care, if it has gone through an internal appeals process and goes to the external independent review panel, that that panel can tell the HMO to give the care. In our bill that passed the House, if the HMO does not give the care, then they are subject to a fine, a rather stiff fine. And if a patient is injured as a consequence of not receiving that care, then that plan would be liable for that. This has not been decided. This has not been decided in the conference.

Furthermore, one would think that this would be an easy thing that could have been decided, and that is that the panel should be independent from the HMO. Apparently, this has not been decided in the conference either. So all of those reports saying that significant progress was being made on the appeals process, I think, are vastly overblown.

Furthermore, I would point out to my colleagues, and I really do not need to tell them this, because all of them that have been here for more than 6 months know this is the case, that unless we see legislative language, we can talk all we want about ''principles,'' but one simple clause in legislative language can totally turn the intent of that provision around. And there is no legislative language available.

So what do we have here? We have a situation where States all around the country are saying we need to do something about this. State legislature after State legislature have passed bills for patient protection. In fact, in Oklahoma, the State legislature just passed a law making it easier for patients to sue HMOs and other insurers for unreasonable denials of medical care. Under the Oklahoma law, a health plan can be required to pay damages if it fails to exercise ''ordinary care'' in treating patients.

The chief sponsor of the Oklahoma bill, State Senator Brad Henry, has said, ''The chairman of the House Senate conference is definitely out of step with the public here in Oklahoma. Polling information shows that 72 percent of Oklahomans support giving the patient the right to sue.''

That Oklahoma measure was not even a close vote. It passed 94 to 5 in the State House of Representatives in Oklahoma and 44 to 2 in the State Senate, and it was signed by Republican Governor Frank Keating on April 28.

Mr. Speaker, I am sorry to say that as time has gone by since we passed this in October last year, a lot of patients are being denied care by some HMOs, and I think are being injured by it. I have here some estimates for how many patients are being injured.

Now, I can give my colleagues specific examples of patients who have been injured. I have done that many times on the floor. I have brought up posters showing their faces. I have brought up posters showing the families of women who have died because of HMO decisions and how they are left without their mother or their wife. But just to give some idea of the magnitude of the problem that we are dealing with, there have been two recent studies from which we can extrapolate how many cases each day in this country we are seeing of HMO denial and abuse causing pain and suffering and injury to patients.

The studies that I am citing here are Helen Schauffler's California Managed Health Care Improvement Task Force Survey of Public Perceptions and Experiences with Health Insurance Coverage from the University of California Berkeley School of Public Health and Field Research Corporation. This was reported in Improving Managed Health Care in California, Findings and Recommendations. And also a study from the Committee Analysis Based on Kaiser Family Foundation and Harvard Public School of Health called Survey of Physicians and Nurses, July 1999.

Here are some of the highlights that my colleagues can take from these studies showing what is going on every day around the country. According to these two studies, every day 59,000 patients, because of HMO inappropriate denials of care, experience added pain and suffering.

According to these studies, every day, 41,000 patients experience a worsening of their medical condition. According to these studies, every day 35,000 patients have had needed care delayed.

Thirty-five thousand patients have a specialty referral delayed or denied every day. Thirty-one thousand patients every day are forced to change doctors. Eighteen thousand patients every day are forced to change medications.

And every day 14,000 physicians see patients whose health care has seriously declined because an insurance plan refused to provide coverage for a prescription drug. Mr. Speaker, every day in this country 10,000 physicians see patients whose health has seriously declined because an insurance plan did not approve a diagnostic test or a procedure.

And every day 7,000 physicians see patients whose health has seriously declined because an insurance plan did not approve referral to a medical specialist. And, Mr. Speaker, every day 6,000 physicians see patients whose health has seriously declined because an insurance plan did not approve an overnight hospital stay.

These are pretty amazing statistics. If we want to talk about the number of patients each year in this country who experience HMO abuse in delay of needed care, we are dealing with almost 13 million.

Each year, 12,800,000 patients experience HMO plan abuse in terms of delay or denial of care. It is about 11 million patients each year in this country that have to change their doctors because of HMOs. It is about 6,500,000 patients each year in this country that are forced to change medications. It is about 22 million patients in this country that each year have added pain and suffering because of HMO decisions and abuse, and about 15 million patients each year in this country see their medical conditions worsen because of HMO abuse.

And here we are. It has been, what, 7, 8 months since we passed the bill in the House? We have been working on this for 4 or 5 years. We could multiply these annual numbers by four or five times and it would begin to approach the magnitude of the problem that we are dealing with on this.

A few years ago, in testimony before my committee, the Committee on Commerce, a small, quiet woman, who was a medical reviewer for an HMO, gave some very compelling testimony. She said that she had actually made medical decisions that had cost patients' lives and that she had been rewarded for that by HMOs. She said, and I am paraphrasing her, ''I am coming clean. I cannot tolerate this any more.'' She said, ''I made a medical decision that cost a man his life. He needed an operation on his heart and I denied it. It was medically necessary for him.''

And then she pointed out what the smart bomb is of cost containment for HMOs, and that is in the area of denials based on ''medical necessity'', which HMOs can arbitrarily define, according to Federal law, any way they want to. Some HMOs even define medical necessity as ''the cheapest, least expensive care.'' Now, think of that for a minute. Would we like our health plan to define medical necessity for us as the cheapest, least expensive care? Now, one might say, well, that would help hold costs down. But it would also result in some really bizarre activities.

Before coming to Congress, I was a reconstructive surgeon. I took care of a lot of kids with cleft lips and palates. The standard treatment for a kid with a cleft lip and a cleft palate is surgical correction. The hole in the roof of the mouth is surgically corrected so that they can learn to speak normally, so that they do not have food coming out of their nose. Under that irresponsible definition of medical necessity, as the cheapest, least expensive care, that HMO would be totally justified in just giving this little baby a piece of plastic to shove up into the roof of his mouth so that food would not come out. Sort of like an upper denture. I think that is really ridiculous.

I have given some talk on this floor about some practice guidelines that a company by the name of Milliman and Robertson, sort of the HMO flack house, has created. If it were not for the fact they have sold about 20,000 of these guidelines around the country to hospitals and HMOs, we would not need to talk so much about this. But in a previous talk here on the floor I gave a lot of examples of how wrong, how far away from standards of care those guidelines are.

I recently got a letter from Milliman and Robertson trying to explain where they come up with some of these. I think this article that is in Pediatrics, the journal Pediatrics, Volume 105, No. 4, April 2000, is a much more scientific approach to analyzing the validity of Milliman and Robertson's guidelines.

Let me just read the conclusion. ''In New York State, during 1995, length of stay for selected pediatric conditions was generally in excess of published Milliman and Robertson guidelines.''

I love how these conclusions always understate what the article says. They say, ''This raises concern about the potential effects of such guidelines on both patients and the hospitals caring for them.'' They go on and say in the text of this, ''Several studies have demonstrated that certain length of stay related guidelines adversely affect patient care,'' and then they list a number of them. I just want to quote some of these to give a flavor for the analysis in the medical literature of some of these ''guidelines.''

Jerome Kassirer, in the New England Journal of Medicine, wrote an article on The Quality of Care and the Quality of Measuring It. Arnold Relman, Reforming the Health Care System, the New England Journal of Medicine. Wilson, in Medical Decision Making, Primary Care Physicians' Attitudes Toward Clinical Practice Guidelines. Fitzgerald, in the New England Journal of Medicine, The Care of Elderly Patients With Hip Fracture: Changes Since Implementation of Prospect of Payment system. Mitchell, Who Are Milliman & Robertson and How Did They Get in My Face?, in the Journal of the Kentucky Medical Association.

Well, what do these articles have in common? They have in common what this article in the journal Pediatrics found, and that was that the length of stay recommendations put out by this company, Milliman and Robertson, are really far out. They say in this article, ''Numerous commentaries in both the lay and medical press have raised concerns regarding the largely unknown impact of guidelines on health of the more vulnerable populations, particularly the elderly, the young, and the chronically ill. Our findings demonstrate that actual pediatric length of

stay in New York State during 1995 exceeded, often markedly, the Milliman and Robertson functional length of stay guidelines. The difference was most marked in diagnoses with long courses of antibiotics, for instance, bacterial meningitis, osteomyelitis, and complicated appendectomy.''

In a previous talk I gave, I pointed out that the average length of stay in a hospital for somebody with a really serious infection, this is for a child, like bacterial meningitis, is somewhere around a week, if not longer. That is usual and that is customary. These kids are really sick. Milliman and Robertson recommends one or two days, one or two days in the hospital for somebody who has a serious bacterial infection of their brain or their spinal cord and who could die from that.

□ 1900

I know something personally about this because about 3 years ago now I had a bad case of encephalitis. It is impossible for me to believe that a patient with even a moderate case of encephalitis could be discharged in 1 or 2 days. It just boggles my mind.

There are many quotes in this study. Let me just read a few. ''Both the Institute of Medicine and the Agency for Health Care Policy and Research have set high standards for the development of guidelines, including the involvement of multi-disciplinary panels and the use of explicit evidence-based approaches. This is a methodology used by governmental groups such as the Institute of Medicine.

''At a minimum, we should expect that the data and methods contributing to Milliman and Robertson's guidelines be available for public discussion and debate.''

They are not, unfortunately.

That is why that lady who was a medical reviewer who testified for my committee said those determinations based on plan guidelines are the smart bomb of HMO's cost containment.

But there is something that needs to be dealt with in terms of the external appeals process that we are dealing with in conference between the House and the Senate. And if they are not dealt with, and as I repeat, to date, my sources on the Republican side tell me they have not been dealt with, then we should not be releasing reports to the press saying that there is significant progress being made in that conference.

I think that the conferees, when they go down to the White House, ought to really make an effort to move on this.

There are many other things that I could speak about in terms of where we are at with various issues related to the patient protection. I want to just deal with about four or five.

The first is that the bill that passed this House on patient protection would lead to a flood of litigation. That is just not true. Our bill was modeled after the bill that passed in Texas about 3 years ago, and there have only been a handful of lawsuits since that time in Texas.

Of those lawsuits, though, I would say several are meritorious. Let me give my colleagues one example.

There is a patient named Mr. Piloseca who was in the hospital suicidal. His doctor recommended that he stay in the hospital to be treated for his suicidal tendencies. His health plan, NYLCare, said, no, no, you are out the door.

Maybe they used their own guidelines. Maybe they used Milliman and Robertson's guidelines. I do not know. They said, you are out the door and we are not going to pay for any hospitalization.

Under that circumstance, under Texas law, where there is a dispute between the physician and the health plan, the health plan is supposed to go to an expedited review to that independent panel for a determination.

What did they do? They just ignored it and said, we are not going to pay for your hospitalization. Unless you want to pay for it yourself, then you are out of here.

Well, this family is of average modest means and they do not have the ability to do that. So Mr. Piloseca went home that night and, sure enough, suicidal that he was, he drank half a gallon of antifreeze and he committed suicide.

That health plan is being sued in Texas. That is one of the handful. But they are being sued because they did not follow the law that was in Texas.

Hardly a flood of lawsuits.

Then there are opponents to our bill that passed the House that say, oh, employers could be sued under the bill that passed the House.

And I will tell my colleagues that, under the bill that passed the House, the Norwood-Dingell-Ganske bill, the bipartisan consensus Managed Care Reform Act, an employer can only be sued or held legally accountable if that employer exercises discretionary authority in making a decision that results in negligent harm to the patient.

Most employers are nowhere near that. I have got lots of small businesses in my district. Those businesses hire an HMO to provide health care for themselves and for their employees. They do not get involved in the medical decision-making. And if they are not involved in the medical decision-making, they cannot be held liable.

Furthermore, in our bill that passed the House, we expressly stated that employers cannot be sued for choosing to contract with a particular health plan, deciding which benefits to include in the plan, or deciding to provide additional benefits not generally covered by the plan.

Mr. Speaker, here is another myth. The myth is that, well, if you just have a strong appeals process, there is no need for any legal accountability.

I would just refer you back to the case I just told you about. If do you not have accountability, what is going to make the HMO follow the law?

I would point out this. Many times I have talked on this floor about a little boy from Atlanta, Georgia, who, when he was 6 months old, was really sick, his mom and dad had to take him to the emergency room in the middle of the night, but he was only given an authorization to go to an emergency room that was about 60 or 70 miles away instead of stopping at any two or three emergency rooms that were very close to their room.

That was a medical decision, a medical judgment, that that reviewer made over the telephone. Unfortunately, he had a cardiac arrest in the car before he got to this far-away emergency room. They managed to keep him alive, but he suffered circulatory loss to his hands and feet and he lost both of his hands and both of his feet.

Now, there was not any chance to have to go to an independent appeals process in that situation. But that HMO made a medical judgment, and they should be responsible for that.

I can give my colleagues several other real-life examples. How about the patient who sustained injuries to his neck and spine in a motorcycle accident. He was taken to the hospital. The hospital's physicians recommended immediate surgery. But the health plan refused to certify that surgery. Time and time and time went on. And what happened? The patient was paralyzed.

How about the patient who was admitted to an Emergency Room in his community hospital complaining of paralysis and numbness in his extremities. The treating room emergency physician concluded that this was a really serious case, he needed to go to the medical school immediately. The health plan denied authorization for a transfer. Hours and hours later, by this time, the patient is now quadriplegic, i.e., paralyzed in both his hands and both his legs.

You need to have accountability, not just on the more leisurely cases that come along, but also from the get-go.

How about this: People say that the bill that passed the House could significantly increase the cost of health insurance and the number of insured. And I say baloney. The Congressional Budget Office looked at our bill, and the legal accountability provision was estimated to raise premiums one percent over 4 years.

A one percent equivalent over 4 years is equal to employers paying a mere 4 cents per day for individual coverage with employees contributing just one additional penny per day.

Now, opponents also of our bill have said, oh, for every one percent increase in premiums, you are going to have 400,000 people lose their jobs. That is baloney, too. Nobody has ever documented where that statistic came from. But the General Accounting Office did a study of it and they said, that is wrong, it is outdated, it does not account for the relevant factors.

So people came back and said, well, maybe it is only 300,000 people will lose

their insurance if premiums go up 1 percent. GAO came back again and looked at that data and said, wrong, wrong, the statistics do not show that.

And furthermore, I would point out this: Between 1988 and 1996, the number of workers offered coverage actually increased in this country despite increased premiums each year.

I would also point out to my colleagues that we did not pass this bill and it has not become Federal law and premiums went up last year. Why? Because the HMOs wanted to show it on their bottom line profit statements for Wall Street.

Then opponents say, well, you know what, consumer support for this bill will evaporate if consumers learn how much it is going to cost them.

Let me cite to my colleagues a 1998 nationwide survey by Penn, Shown & Burlin that 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 such a bill if their premiums increased between $1 and $4 a month, 78 percent, more than three-fourths of the people in this country, said, you bet.

Now, I want to tell my colleagues what the bill that passed the House would cost. The House-passed bill would raise insurance premiums an average of 4.1 percent, covering to the Congressional Budget Office, over 4 years. Do my colleagues know how much that would account for an individual?

Remember, 78 percent of people in this country say that they want to see Congress pass this law even if it means to them an increase in cost between $1 and $4. Dollars. For an individual, that percentage increase would cost $1.36 per month and, for a family of four, $3.75 per month.

Do my colleagues know what? That is less than what a Big Mac meal costs me out at National Airport. And that is giving people assurance that all the money that they are spending for their health insurance actually means something when they get sick.

I think that is why a recent public opinion survey found that most Americans believe problems with managed care have not improved, 74 percent, and most think that legislative action is either more urgent or equally urgent as it was when this debate began several years ago, 88 percent. That is from the Kaiser Family Foundation survey of February this year.

Mr. Speaker, it is clear, when we start looking at how many patients every day are being injured or denied care because Congress is sitting here doing nothing, or maybe because some Members of Congress are listening to the insurance industry and the HMO industry, we need to get something done on this.

I just want to go over these figures one more time for my colleagues. According to a couple reports that I have cited earlier, every day, as a result of inaction in this Congress for addressing this HMO problem, we are seeing 59,000 patients experience added pain and suffering, we are seeing 41,000 patients experience a worsening of their medical condition, we are seeing 35,000 patients having needed care delayed, 35,000 patients with a specialty referral delayed or denied, 31,000 patients are forced to change doctors, and 18,000 patients are forced to change medications needlessly.

Mr. Speaker, it should be clear that the conferees to the HMO reform bill should really get off their fannies and get to work. When they go down to the White House on Thursday, as I hope they do, I hope in good faith they sit down and try to get something done and not just try to ride out the time clock on this year.

Mr. Speaker, I am happy to yield to my friend and colleague the gentleman from California (Mr. HORN). I know he wants to speak some about health care, also.

Mr. HORN. Mr. Speaker, I thank the gentleman for yielding to me. He has been marvelous in terms of bringing to the American people the need for a decent health care program.

Mr. Speaker, health care paperwork has become a complex and often confusing problem for many Americans. Many of us have experienced the confusion of erroneous billings, lengthy delays in reimbursement, and troubling disputes about what is and is not covered under a health care plan.

These problems are of particular concern in the Medicare program, the largest purchaser of health care in the world and a program that is absolutely vital to nearly 40 million senior citizens who rely on its services.

In the early 1990's, the Medicare program was designated as one of the Government's high-risk programs by the Comptroller General of the United States and his General Accounting Office.

Medicare's size, complexity, and lack of management controls are a problem and worthy of our attention. Each year the House Subcommittee on Government Management Information and Technology, which I chair, conducts oversight hearings to determine what progress has been made in resolving the management problems within Medicare. Each year we are told that significant progress has been made and more is expected soon.

□ 1915

Mr. Speaker, it is true that progress has been made. Two years ago, the Inspector General of the Department of Health and Human Services reported that erroneous bills in the Medicare program totalled an estimated $20.3 billion in fiscal year 1997. That was 11 percent of all Medicare billings that year. In short, one of every $10 spent by Medicare was an improper payment. This year, the Inspector General, the very able June Gibbs Brown, returned to testify that the error rate was now estimated at $13.5 billion for fiscal year 1999, or about 8 percent of total billings.

As I said, that is in fact progress. We are moving in the right direction, but I am still stopped cold by those numbers. Medicare improperly paid out $13.5 billion last year for claims that were not covered by the program, for claims that were, to quote the General Accounting Office, ''not reasonable, necessary and appropriate.''

Mr. Speaker, all of us know that the Medicare program is a very large and complex operation and presents an enormous management challenge. The program still operates under the rules set in 1965. Medicare uses private insurance companies as the contractors and intermediaries between the patient, the doctor, the hospital to process bills and those that go to Medicare. That paper flow is a virtual Niagara Falls. Every day, the Medicare program's contractors process about 3.5 million claims worth an average of more than $650 million a day. That is every day of the year. Managing this flow is indeed a major challenge.

But, Mr. Speaker, the challenges in the Medicare program are not new. Medicare has been in existence for 35 years and its specific management problems have been documented in excruciating detail by a long list of reports from the Inspector General and the Comptroller General of the United States, the head of the General Accounting Office. Even with all of the attention and concern, serious management deficiencies continue to plague this program and waste or misspent billions of Medicare dollars.

In all of the reports on Medicare's problems, the key recommendation has been this. Medicare must develop a fully integrated financial management system, standardized with all of its contractor intermediaries so that timely, accurate and meaningful information can be developed to control this $300 billion a year program.

Mr. Speaker, today I am introducing H.R. 4401. This legislation can move us toward the goal of first rate management. This bill has been introduced in the other body by Senator RICHARD LUGAR of Indiana. I have a very high regard for Senator LUGAR. His bill in the other body is S. 2312, and H.R. 4401 is similar to his legislation. In brief, we are working together and the two of us believe that enacting sound and effective controls on the Medicare program must be made a very high priority.

The Health Care Infrastructure Investment Act is designed to force the creation of an advanced information infrastructure that will allow the Medicare program to instantly process the vast number of straightforward transactions that now clog the pipeline and drain off scarce health care resources. The bill calls for the development and implementation of an integrated system so that Medicare and its contractors can serve seniors with immediate points of service and

verification of insurance coverage, point of service checking for incomplete or erroneous claim submission, and point of service resolution of simple, straightforward claims for doctor's office visits, including the delivery of an explanation of benefits and payment that the patient can understand. That means that when Medicare beneficiaries walk into the doctor's office, they can know immediately what their benefits are and what copayments or deductibles apply. When they leave, they will receive a simple statement of what was done and what is owed.

Our bill is careful to avoid mandates that would undermine privacy rights. Privacy is of paramount concern and must be safeguarded in the design of an advanced network of financial management systems for Medicare. The goal of H.R. 4401 is to reduce and, where possible, to eliminate paperwork. Greater efficiency will free doctors to spend more time treating patients, doctor's offices and insurance companies should be able to reduce the cost of claims processing, and patients will be fully informed about treatments and costs.

Mr. Speaker, this legislation could save the taxpayers billions of dollars every year, and it would not be wasting Medicare access, either. It would get us to modernize the paperwork and the inefficiencies and put an end to many time-consuming and confusing complications in the billing process for doctor office visits, and both for doctors and for patients.

This bill, H.R. 4401, also can lay the foundation for modernizing Medicare's financial management systems so that the annual reports of billions of dollars misspent will become a thing of the past. Then we can be assured that every Medicare dollar is being properly used to pay for the health care our seniors need. Our bill, H.R. 4401 in the House, will be sent to the Committee on Commerce, the Committee on Government Reform and Ways and Means.

Mr. Speaker, I ask that H.R. 4401 be printed below.

H.R. 4401

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Infrastructure Investment Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Moratorium on delayed payments under contracts that provide for the disbursement of funds.
Sec. 3. Establishment of the Health Care Infrastructure Commission.
Sec. 4. Study and final recommendations; timetable for implementation of advanced informational infrastructure.
Sec. 5. Application of advanced informational infrastructure to the FEHBP.
Sec. 6. Authorization of appropriations.

SEC. 2. MORATORIUM ON DELAYED PAYMENTS UNDER CONTRACTS THAT PROVIDE FOR THE DISBURSEMENT OF FUNDS.

Section 1842(c) of the Social Security Act (42 U.S.C. 1395u(c)) is amended by striking paragraph (3).

SEC. 3. ESTABLISHMENT OF THE HEALTH CARE INFRASTRUCTURE COMMISSION.

(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Health Care Infrastructure Commission (in this section referred to as the ''Commission'') to coordinate the expertise and programs within and among departments and agencies of the Federal Government for the purposes of designing and implementing an advanced informational infrastructure for the administration of Federal health benefits programs.

(b) DUTIES.—The Commission shall—

(1) establish an advanced informational infrastructure for the administration of Federal health benefits programs which consists of an immediate claim, administration, payment resolution, and data collection system (in this section referred to as the ''system'') that is initially for use by carriers to process claims submitted by providers and suppliers under part B of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) after conducting the study under section 4(a)(1);

(2) implement such system in accordance with the final recommendations published under subsection (a)(2) of section 4 and the timetable set forth under subsection (b) of such section; and

(3) carry out such other matters as the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in consultation with the other members of the Commission, may prescribe.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 7 members as follows:

(A) The Secretary, who shall be the chairperson of the Commission.

(B) One shall be appointed from the National Aeronautics and Space Administration by the Administrator.

(C) One shall be appointed from the Defense Advanced Research Projects Agency by the Director.

(D) One shall be appointed from the National Science Foundation by the Director.

(E) One shall be appointed from the Office of Science and Technology Policy by the Director.

(F) One shall be appointed from the Department of Veterans Affairs by the Secretary.

(G) One shall be appointed from the Office of Management and Budget by the Director.

(2) REQUIREMENTS.—Each of the members appointed under subparagraphs (B) through (G) of paragraph (1) shall—

(A) have been appointed as an officer or employee of the agency by the President by and with the advice and consent of the Senate; and

(B) be an expert in advanced information technology.

(3) DEADLINE FOR INITIAL APPOINTMENT.—The members of the Commission shall be appointed by not later than 3 months after the date of enactment of this Act.

(d) MEETINGS.—

(1) IN GENERAL.—The Commission shall meet at the call of the chairperson, except that it shall meet—

(A) not less than 4 times each year; or

(B) on the written request of a majority of its members.

(2) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(e) COMPENSATION.—Each member of the Commission shall serve without compensation in addition to that received for the services of such member as an officer or employee of the United States.

(f) STAFF.—

(1) IN GENERAL.—The chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties.

(2) COMPENSATION.—The chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(3) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(g) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(h) TERMINATION.—The Commission shall terminate on the date on which the system is fully implemented under section 4(b)(3).

SEC. 4. STUDY AND FINAL RECOMMENDATIONS; TIMETABLE FOR IMPLEMENTATION OF ADVANCED INFORMATIONAL INFRASTRUCTURE.

(a) STUDY AND FINAL RECOMMENDATIONS.—

(1) STUDY.—The Commission shall conduct a study during the 3-year period beginning on the date of enactment of this Act on the design and construction of an immediate claim, administration, payment resolution, and data collection system (in this section referred to as the ''system'') that—

(A) immediately advises each provider and supplier of coverage determinations;

(B) immediately notifies each provider or supplier of any incomplete or invalid claim, including—

(i) the identification of any missing information;

(ii) the identification of any coding errors; and

(iii) information detailing how the provider or supplier may develop a claim under such system;

(C) allows for proper completion and resubmission of each claim identified as incomplete or invalid under subparagraph (B);

(D) allows for immediate automatic processing of clean claims (as defined in section 1842(c)(2)(B)(i) of the Social Security Act (42 U.S.C. 1395u(c)(2)(B)(i)) so that a provider or supplier may provide a written explanation of medical benefits, including an explanation of costs and coverage to any beneficiary under part B of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) at the point of care; and

(E) allows for electronic payment of claims to each provider and supplier, including payment through electronic funds transfer, for each claim for which payment is not made on a periodic interim payment basis under such part.

(2) FINAL RECOMMENDATIONS.—

(A) PUBLICATION.—Not later than 3 years after the date of enactment of this Act, the

after the date of enactment of this Act, the chairperson of the Commission shall publish in the Federal Register final recommendations that reflect input from each interested party, including providers and suppliers, insurance companies, and health benefits management concerns using a process similar to the process used for developing standards under section 1172(c) of the Social Security Act (42 U.S.C. 1320d–1(c)).

(B) CONSIDERATIONS.—In developing the final recommendations to be published under subparagraph (A), the Commission shall—

(i) make every effort to design system specifications that are flexible, scalable, and performance-based; and

(ii) ensure that strict security measures—

(I) guard system integrity;

(II) protect the privacy of patients and the confidentiality of personally identifiable health insurance data used or maintained under the system; and

(III) apply to any network service provider used in connection with the system.

(b) TIMETABLE.—The timetable set forth under this subsection is as follows:

(1) INITIAL IMPLEMENTATION.—Not later than 5 years after the date of enactment of this Act, the system shall support—

(A) 50 percent of queries regarding coverage determinations;

(B) 30 percent of determinations regarding incomplete or invalid claims; and

(C) immediate processing at the point of care of 40 percent of clean claims submitted by providers and suppliers under part B of the medicare program.

(2) INTERMEDIATE IMPLEMENTATION.—Not later than 7 years after the date of enactment of this Act, the system shall support—

(A) 70 percent of queries regarding coverage determinations;

(B) 50 percent of determinations regarding incomplete or invalid claims; and

(C) immediate processing at the point of care of 60 percent of clean claims submitted by providers and suppliers under part B of the medicare program.

(3) FULL IMPLEMENTATION.—Not later than 10 years after the date of enactment of this Act, the system shall support—

(A) 90 percent of queries regarding coverage determinations;

(B) 60 percent of determinations regarding incomplete or invalid claims; and

(C) immediate processing at the point of care of 40 percent of the total number of claims submitted by providers and suppliers under part B of the medicare program.

SEC. 5. APPLICATION OF ADVANCED INFORMATIONAL INFRASTRUCTURE TO THE FEHBP.

(a) IN GENERAL.—The Office of Personnel Management (in this section referred to as the ''Office'') shall—

(1) adapt the immediate claim, administration, payment resolution, and data collection system established under section 3 (in this section referred to as the ''system'') for use under the Federal employees health benefits program under chapter 89 of title 5, United States Code; and

(2) require that carriers (as defined in section 8901(7) of such Code) participating in such program use the system to satisfy certain minimum requirements for claim submission, processing, and payment in accordance with the timetable set forth in subsection (b).

(b) TIMETABLE.—The timetable set forth in this subsection is as follows:

(1) INITIAL IMPLEMENTATION.—Not later than 5 years after the date of enactment of this Act, the Office shall require that carriers use the system to process not less than—

(A) 50 percent of queries regarding coverage determinations;

(B) 30 percent of determinations of incomplete or invalid claims; and

(C) immediate processing at the point of care of 10 percent of the total number of claims.

(2) INTERMEDIATE IMPLEMENTATION.—Not later than 7 years after the date of enactment of this Act, the Office shall require that carriers use the system to support not less than—

(A) 70 percent of queries regarding coverage determinations;

(B) 50 percent of determinations regarding incomplete or invalid claims; and

(C) immediate processing at the point of care of 20 percent of the total number of claims.

(3) FULL IMPLEMENTATION.—Not later than 10 years after the date of enactment of this Act, the Office shall require that carriers use the system to support not less than—

(A) 90 percent of queries regarding coverage determinations;

(B) 60 percent of determinations of incomplete or invalid claims; and

(C) immediate processing of 35 percent of the total number of claims.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are appropriated to the Health Care Infrastructure Commission established under section 3, out of any funds in the Treasury that are not otherwise appropriated, such sums as may be necessary to carry out the provisions of this Act.

(b) AVAILABILITY.—Any sums appropriated under subsection (a) shall remain available until the termination of the Health Care Infrastructure Commission under section 3(h).

The SPEAKER pro tempore (Mr. SUNUNU). The gentleman from Iowa (Mr. GANSKE) has 18 minutes remaining.

Mr. GANSKE. Mr. Speaker, I just point out that my colleague from California has been a stalwart in working on matters of health concern for his constituents and in particular has been very strong on supporting a Patient's Bill of Rights. I appreciate his work and effort in that very much.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all Members to refrain from references to individual Senators.

EDUCATION REAUTHORIZATION

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentlewoman from California (Ms. MILLENDER-MCDONALD) is recognized for 60 minutes.

Ms. MILLENDER-MCDONALD. Mr. Speaker, I start today by talking about the person whose name I carry and the reason I have such a long name on the board. That name is MILLENDER, JUANITA MILLENDER-MCDONALD. It is because of my father, Reverend Shelly Millender, who taught us that education is important, that we must have a quality education in order to challenge the world that would be before us. And so, Mr. Speaker, tonight I rise with several of my colleagues to discuss the reauthorization of the Elementary and Secondary Education Act known to us as ESEA.

This act is an act that is of immense importance to our children and the future of our Nation. The education of our Nation's children is an issue of paramount concern. As Members of the House of Representatives, it is imperative that we remain focused on our national priorities of raising standards and providing special assistance to children in need to ensure that all students are prepared to face the challenges of the 21st century. Globalization has brought us into a more competitive world where the challenges of technology will dominate the economic relations among world nations. If all of our children are not prepared to face these challenges, our great country will not continue to lead the world in the vital areas of economy and technology, and also in the critical areas of democracy and political participation.

We must, Mr. Speaker, guarantee quality school facilities, quality teachers, smaller classroom sizes and gender equity in technology so that all of our children, both boys and girls, are able to face these new challenges.

I stand with some of my Members who are on the floor today as we recognize America's teachers. As a former teacher, I know the importance of teachers and their leadership to the classroom, but more importantly their leadership for the future, for our future, America's future because they are guiding our children who will be the leaders of tomorrow. Some of them will be the Members of Congress. Therefore, we must instill in them not only the moral standards, character building, but also quality education, quality education that comes from good teachers. I stand today in that salute and recognize the importance of teachers in this whole process.

In the 106th Congress, the authorization of Federal aid to many education programs covered under the Elementary and Secondary Education Act known as ESEA is expiring. These bills have passed through the House in a piecemeal approach to reauthorizing major ESEA programs. It is expected that the final piece of the ESEA puzzle, H.R. 4141, will be coming to the floor soon. H.R. 4141, the Education Opportunity to Protect and Invest in Our Nation's Students Act, also known as the OPTIONS Act, amends ESEA programs regarding education technology which is part of title III, the safe and drug-free schools and communities that is couched within this title III. It also amends title IV, and the education block grant which is title V.

I am deeply concerned, however, Mr. Speaker, with title I of H.R. 4141, entitled the transferability. Transferability is essentially a backdoor block grant program which would allow Federal funds intended to target technology, teacher training, school safety and after-school care needs to be used for any purpose deemed educational regardless of its relevance to the core mission.