Those are the things that I am indebted to RON DELLUMS for.

But my respect goes beyond that. My admiration goes beyond that, because RON has been willing to share with people and to spend time with young people. I will never, ever forget eating lunch in one of the House facilities here with my son and a friend of his from his college class. We had almost finished eating when RON entered the dining room, and RON came over and sat down with us as we were about to leave, we thought. And about an hour later he was still mesmerizing these two college students with stories about how he had gotten involved in politics, how he had come to understand the principles and commitment that one has to make to gain the respect and admiration of others, and how he valued the opportunity to serve his constituents and the people of America.

There is nobody in this body that I admire and respect more than I admire and respect RON DELLUMS. I am going to miss him immensely. It has been wonderful over the last several days to hear the tributes that have been made to RON DELLUMS and to learn more and more about this powerful, beautiful man.

I wish him well. I wish him success in everything that he endeavors. I understand the circumstances under which he is leaving this body, and I hope that he will have much success with those circumstances. I just simply want to take this moment to express my respect and admiration for this powerful, powerful man.

HEALTH CARE IN AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentlewoman from Texas (Ms. SHEILA JACKSON-LEE) is recognized for 60 minutes as the designee of the minority leader.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I am pleased to be able to discuss what I believe is a very important issue and need in this country, and I could first start speaking generally about the value of good health care and how health care touches all Americans, how health care is bipartisan, not a respective race or agenda or region. It really is the desire of all people to have good health care, good and safe and viable and, yes, reasonable health care.

But even as we talk about reasonable health care, I think it is important that that word be put in the context of the right kind of medical professional-patient relationship and interaction. Just a few hours ago there was an extensive debate on the floor of the House regarding attorneys' fees for the White House Task Force on Health. During that debate I indicated that I thought my colleagues were moving in the wrong direction, a punitive direction rather than a helpful direction, and, in fact, the question of who should pay attorneys' fees for a challenge to that task force really begs the question and really took up the time of the American people in the wrong way.

We passed no effective health legislation by that vote. And I voted against it because I thought that it simply missed the point of the House Health Task Force that, in fact, did not conclude with a decision as to which type of health care this whole Nation would buy into, but they did do something very important. They put in the minds of the American people that we had a health system that needed repair and, in fact, all was not well and there were other options that we might look at.

Whether it was universal service or access universally to health care, or whether or not it had to do with physician assisted plans, or whether or not it had to do with the professional health maintenance organizations, which have now about taken over the country, it still raised the debate. And, yes, it talked about the importance of making sure that all aspects of our community, our children, our infants, our senior citizens, our working families had access to health care. And today we find that we do have and still have a broken system.

Many of us can rise to the floor of the House and share personal stories. For example, my father, who suffered from cancer, not unlike many families in America, a senior citizen who, in fact, had been healthy every day of his life and was shocked that there was now something wrong with him. In the family's eyes there was nothing wrong with him. He was ill and we wanted him to be better. But in his mind there was something wrong, and we needed a sensitive and responsive health maintenance organization. I am sorry to say we did not get that.

How many times I have heard from constituents who indicate that it seems like the question of cost was more the priority of their health maintenance organization than it was quality of service and the wellness of the patient.

I do not believe Congress can proceed any further without assessing the need for better health care and good health care. We already have noted that 88 percent of the American public supports a consumer Bill of Rights as it relates to HMOs. Eighty-two percent support tax breaks and grants and subsidies for child care that also has an impact on how our children are cared for and also a better quality of life. But always the health care rises to the level of importance.

The attractiveness of a tobacco settlement focuses on opportunities to improve the health of Americans, to ensure that we diminish the opportunity for Americans to suffer through smoking and the illnesses that come about. But no matter how much we tell Americans to be healthy and to participate in wellness programs, if we have a broken health system, if we have HMOs that are governing and controlling all of the health systems around this Nation with little sensitivity to the importance and the sacredness of the patient-physician relationship, or the patient-professional medical practitioner relationship, then we do not have a system.

So Americans are very interested in this consumer protection Bill of Rights, and I believe we must drive this to the end and it must be passed. And so I call upon my colleagues and the leadership of this House, the Republican leadership, to let us stop dividing along the lines of party when it comes to health care. No one in America goes to their physician and asks for their voting card. They want a good physician. They want the kind of physicians who carefully guided into this world those wonderful septuplets in our Midwest now, as we watch each healthy baby leave the hospital.

Those two young physicians, young women, in fact, might I say, cared enough about those lives and the good health of both the mother and those babies to meticulously and carefully and without any question of cost to proceed to bring and to help as God's creations were being born.

And so it is important that we understand what Americans want. No, they do not want fraud and abuse. But if there had to be a question of whether or not they could readily and carefully and with expertise help bring those septuplets into this world, help them be born, help create a unique time in history, I do not think Americans would want HMOs standing outside the door of that young couple saying, well, you know, you have to make a decision.

□ 1945

The cost is too much to get and to have septuplets. What an outrageous thought. But that is what many Americans are feeling with the kind of HMOs we have in America. Calls being made to corporate institutions by physicians and physicians saying, ''No, they cannot have that transplant. How old are they? There is not enough money in their coverage. How old are they?'' And as the decision is being deliberated and the arguments are being made long distance, someone, your loved one, is dying. Americans are saying, enough is enough.

I am gratified that we have this opportunity to fix this system, that we have not gone too far. Coming from an area that has the Texas Medical Center and premier hospitals, in particular one that I happen to serve on the advisory committee for prostate cancer, M.D. Anderson, I know that most of the health officials want to do their job efficiently, effectively, with great recognition of cost; and they want to save lives; and they want to go to any length to save lives. We must give them that opportunity. Our HMOs are stifling good health care in America.

Oh, yes, there are some that provide easy access by way of the cost that one pays for an office visit. But, in many

instances, the physicians are overloaded, having to match a certain number of visits per day, having to move patients out in a certain period of time, some tell me 15 minutes or less, sort of a factory type sense, being penalized if they take a longer period of time to ask questions of that senior citizen who may have a difficult time communicating, that person who does not speak English, that child who is younger and has a difficult time explaining to the physician and to mommy or daddy where the pain is. I have heard these stories.

My colleague from Tennessee has said that we even have some difficulties in administrative regulations relating to home health care. We find that these agencies are proliferating, but we understand as well that there is a need.

Many of our health needs revolve around home-bound patients who need to be with family and in warm surroundings, as opposed to the possibility of a sterile hospital; and they need these visits from home health care officials. Yet we are creating hassles, if you will, for those businesses to survive, many of them small businesses; and we are creating financial hurdles for them to jump through, so that they cannot have that kind of care.

If I may personalize this again, at the time of the height of my father's illness, he needed around-the-clock, 24-hour care. It was much better for him to be at home than it was for him to stay at a hospital of which there was at that time, very sadly, not much to be done. But yet, we find ourselves in controversy because these kinds of opportunities and choices are being denied.

So I am delighted to be able to support the Democratic Health Task Force proposal for a patient bill of rights, to have been able to work through this and work with the task force as it looked first at child health care. We saw in the last budget fiscal year 1998 $24 billion that was allotted for children's health, to see the numbers of immunization rise and the numbers of preventable diseases that would, in fact, be destructive of our children's health, to see those diseases go down because our children are being immunized.

So we see what can happen when we turn our attention effectively to the whole question of good health care.

What does the patients bill of rights, the access to care, what does it really mean for America? Well, let me tell my colleagues what it means.

And I can simply say that it means a smile on every American's face. It means a comfort level for some daughter who is worried about her elderly mother in another State and where she only has the ability to consult with that mother's medical professionals by telephone and is not really aware of what kind of care that mom is getting or whether or not she is being short-changed.

It means a choice of plans. We have found that giving consumers choice, allowing them to pick what fits their needs, enhances consumer satisfaction.

So, we, as Democrats, would allow a limited point of service option for employees who were only offered one health plan and that health plan was a closed panel HMO. The health plan, not the employer, would be required to make available another point of service option for those beneficiaries who wanted it. Being released, unshackled, if you will, taking a breath of relief that they would actually be able to express dissatisfaction with their HMO and still have good health care. They are not boxed in.

I just want us to think for a moment. Maybe the American public is not familiar with how far we have come and how low we sunk in health care in America.

Just a year or so ago, we had the drive-by maternity hospitalization. Mothers were being dispatched out of the hospital in 24 hours, and those who had what we call a Caesarian section were cast out in 4 hours. Drive-by deliveries. It took Congressional legislation, working with the Senate, that time Senator Bradley and others, working with the Women's Caucus and many others.

I remember cosponsoring and working on that legislative plan to extend the time that mothers who were delivering their precious baby to be cared for with the right kind of care in the hospital that they were in.

Only those of us who may have first-hand experienced all of the excitement and the doubt and the needs of care of giving birth would be able to fully appreciate, along with, of course, the father and relatives, the need for care.

I heard terrible stories from constituents of their fear and apprehension of that moment of delivery and then the next moment when they barely have had a chance to be able to be cared for, to be able to be stabilized, the baby stabilized and because of their HMO they were dispatched, turned away if you will, out of the hospital.

Have any of my colleagues heard of postpartum depression? Most females will be able to share that with you, a serious condition. Is anyone able to detect that in a 24-hour time period? Well, that is what we had just a short period of time.

What about the story of this daughter whose elderly father was delivered home in a taxicab from a hip replacement surgery to a mobile home in Florida and left at the doorsteps with a walker, no home health care, no training as to how to use the walker, no one to help him use the bathroom facilities, no knowledge of how he would fix his food, because he had to be removed from the hospital because of his HMO?

These are just the tip of the iceberg of the stories that you have heard because cost has been the ultimate decider of health care rather than the care, nurturing and then the eventual wellness of the patient. So choice of plans. Because, ''If your HMO cannot provide you with the guidance and necessary physician care, then go somewhere else.''

What about the quality and the expansiveness of the providers? We say plans must have a sufficient number, distribution and variety of providers to ensure that all enrollees receive covered services on a timely basis. This way, again, you are not confined or boxed in; and you do not have a sense that you are not able to get the breadth of diversity that one might need.

I would probably give it away if I talked about my admiration for that TV doctor that used to carry the little black bag and visit people in their homes. I would really be dating myself if I said that my first doctor visited us in the home. What a special privilege to be home sick from school, warmed in a bed, and to have your physician travel all the way to your house.

Those were, in fact, the good old days of which we will not return. But I think Americans want the old-fashioned medicine, that their care and their nurturing is the first priority, not some bottom-line figure where someone is arguing that the red ink overcomes the need for the care of your loved one.

So we are looking to have specialty care. Patients with special conditions should have access to providers who have the records and expertise to treat their problems.

Our particular proposal of the patients bill of rights allows those patients with special needs, diabetes, MS, special forms of cancer, to be treated, liver disease, to be treated at the level that they have need. Those who need various specialists with relation to allergies, something very unique and isolated sometimes. But if they suffer from that and their HMO says, no, you cannot go to a specialist, it is not life-threatening, or let me say to them that it may not be life-threatening to someone in corporate America in a cubicle in New York, but certainly I would say to them that it totally damages and takes away the quality of life and the kind of health care that we have come to appreciate.

So that specialty care is something that I frequently heard from constituents, ''I have been denied the right to see a specialist. They told me I could not do it. My HMO refused. I could not get a second opinion.'' You develop a relationship with that physician, and you certainly develop a relationship if you have a chronic illness.

In many instances, chronic is not terminal. But it does mean that they need to be under constant care. They are seriously ill. They require continued care. So we are saying that if that is the case and they require continued care by a specialist, the plan must have a process for selecting a specialist as the primary-care provider and assessing necessary specialty care without impediments.

What that means is that, rather than them going to a general practitioner,

who certainly does an enormous job in our community, and I encourage the further training of general practitioners, but if they have such a degree of chronic illnesses that they need a specialist more than they need the general practitioner, they should be able to utilize that as their primary physician, and there should not be, again, the hoops and the wagons and the races that they would have to run to get that done.

I have heard in many cases as we have made progress in the detection of breast cancer and other women-related illnesses that part of the success of that has been early detection. Yet, in many instances, women have not been able to, under the present HMO provisions and what HMOs have been willing to pay for, they have not been able to get OB-GYN services. So it is extremely important and we think it is vital that women have the ability to designate an OB-GYN as a primary-care provider.

Why should that be outside the loop of medical care? Might I say, in this day and time, what a blatant form of discrimination that necessary health care services had to be argued for rather than automatic. How many times we have heard our surgeon generals preach wellness prevention; and, in essence, without a complementary system to be able to provide for that, there is no wellness, there is no care.

□ 2000

So we have a provision that deals with women's protections, and that is extremely important.

Continuity of care. There is nothing more frightening than to have care and to lose it and to need it, and that has come about to many of us because of a change in a plan or a change in a provider's network status. So we thought it was extremely important in our task force to lay out guidelines for the continuation of treatment in these instances, and particular protections for pregnancy, terminal illnesses, and institutionalization.

It is a horrific impact on families when all of a sudden someone loses their job, and they have a child or a loved one who is suffering and has a terminal illness or some other condition that needs constant medical care. What an overwhelming burden on the family.

Already many of us have heard of situations in our community where there are barbecues or fish fries or fire departments and police departments and communities rallying around families who need transplants. I frankly am outraged about that process. Those are particular incidents where there is a great need to be able to have the money, where money is not, and communities rally.

Well, imagine yourself caring for a very ill loved one and you lose your job. How many of us have had the experience of some bad times or hard times come in the midst of the caring for a loved one who needs a great deal of care?

We think it is imperative that there are guidelines that will carry you as a bridge over troubled waters so there is never a point where you come to the flat Earth theory, you get to the edge, and you completely fall off the edge; no hope, no safety net, no ability to carry that care forward. Believe me, my friends, that is not an isolated set of circumstances.

So that is why I am moved to say debates like who is paying the White House health task force attorneys' fees is tomfoolery to a certain extent, when we have Americans who are without good health care, and we have really got to get on the ground working on this consumer protection bill, this patient bill of rights, because as I listened to those who are seeking help from the government to make health care accessible, but the best it can be, these are the kind of hard issues that these providers face every day.

When I say that, the health professionals in our public hospital system, the health professionals in our private hospital system, every day they are dealing with life-or-death issues, questions of how do you pay for health care, how do you utilize Medicaid in the best way it possibly can be used.

So as we balance HMOs, we must also look at making sure that Medicaid is effectively utilized, and that it, too, reaches the necessary patient base that goes without health care if they do not have coverage under Medicaid. Frankly, that is many of our children.

So I would like us to look both at those of the very poor, those who are in need of coverage of Medicaid, as well as those individuals who are operating under HMOs.

Another point that we want to see HMOs improve on is emergency services. Individuals should be assured that if they have an emergency, those services will be serviced by the plan.

Let me give you an example of just some problems that sort of relate to emergency services. It is the question, one, of denial. That means you are not covered. You think it is an emergency, you are driven to the emergency room, but in fact your HMO will not allow that. I guess tragically, unless you come with a bullet wound and unable to speak, that is not always the kind of emergency that occurs.

I heard tell of tragic stories where patients have driven themselves to the emergency room with a near heart attack, needing immediate assistance, and the first thing that the emergency room is forced to ask is, do you have health insurance. Might I say that I have heard of tragedies that have resulted in death because hospital emergency rooms had to be too engaged in finding out whether this patient, who has come into the emergency room, has the necessary health coverage.

Part of that certainly is the way our whole system has been structured. Part of it is the overwhelming fear that HMOs instill in all kinds of health providers, we are not going to pay for this. And in many instances it originally started with good intentions,. The whole idea is to make more cost-effective our managed care system, but in actuality it became the death knell for many who needed good health care.

There is a big debate about research and clinical trials. Not when you go to the National Institutes of Health, and many of our research hospitals. Talk to the community that suffers extensively, any community, from HIV, those both infected and affected. They realize how important clinical trials are and the fact that many people could not participate if they did not have such participation covered or allowed by their health insurance.

So they should be able to engage in clinical trials because that treatment may be the only treatment that is possibly able to cure their tragic illness, and certain approved clinical trials we believe should be allowed under the HMOs. And right now you are more than climbing through hurdles, you are swimming rivers, climbing mountains, and then jumping off and flying like an eagle to even think of getting the approval of an HMO for clinical trials.

We believe that drug formulas, prescription medication, should not be one size fits all. There should be plans that allow beneficiaries to access medication that is not formulary when the medical necessity dictates.

We also think that there should be nondiscrimination against other health care services. We should not be discriminating against our enrollees on a variety of factors, including genetic information, sexual identity and disability.

Very serious point that raises a great deal of consternation is preexisting disease. That has always been a problem, and I believe that the patient bill of rights has to rein in this whole issue of preexisting disease and any bar that it gives to the whole idea of not being able to get good health care.

We want this to be an encompassing package. We want to be able to take away the aura around health care, the fear. In the early stages, or the good old days, as I have mentioned, it was merely the respect that most Americans had for their physicians and the great belief that they did all they could for them, so it was sort of an accepted posture, if you will, where there was sort of this great, great elevation of our physicians.

That is all right, that is voluntary. That came about through competence and trust. Now, however, much of the relationship is out of absolute fear, fear of losing your health insurance, fear of being told you cannot get this surgery, fear of waiting long periods of time for approval to come from some corporate office, some insensitive, nonknowing analyst that has to respond to the HMO's criteria of selection.

This is not an indictment of those professionals who work in the corporate structure. They are guided by

the numbers that have come down that they must respond to.

So we want to make sure that we break the aura of fear, devastating fear, and provide health plan information so that you can have and make informed decisions about your health care options and know what is in your plan, and not have pages and pages of small print that someone passes out to you in your corporate mail and you have no knowledge of what you are accepting or rejecting.

Medical records need to be kept confidential, and that has to be a key element of the patient bill of rights. Patients should be able to accept the fact that their medical records are confidential so that they cannot be used against them by their HMOs. Many times there must be that link, that ombudsman, or woman, that you can comfortably go and show your confusion as a consumer of health care and be able to have answers being given to you.

We will not get a health system that works if we act in fear. We will not get one that works if we do not act. We simply will not have the kind of health care that all Americans can be proud of if we do not take a stand on behalf of the millions of patients, far more than the numbers of HMO organizations that dominate our country.

We are told that some States have nothing but HMOs. We have seen our physicians hover in fear because of HMOs. I have had physicians from certain communities, in particular the Indian community, that have acknowledged seemingly the lack of cultural understanding, the needs of their patients, the intrusion of the HMO into the kind of care that they need to give.

The one thing we pride ourselves about here in this country is freedom, freedom of choice, the ability to go where you feel most comfortable; certainly not to do damage to anyone else, not to tread on anyone else's freedom, but certainly the freedom to get what you desire and need.

We think it is important that as we break this aura of fear, that we assure the American public that they have quality health insurance, that the plans are working the way they should, doing what they should, that the caliber of physicians are at the level that they should be, so we support quality assurance, monitoring the HMOs and their service over a period of time. We think it is important to collect data, to be able to see how many success stories, how many cure stories, if we might, what are the surgeries and their success rate. Are we looking at the kind of plans that have the kind of health professionals and hospitals that provide the best care.

I think it is very important that we have HMOs that reflect the community. I have been very much a strong advocate in my own district, in Houston, of encouraging Hispanic and African American physicians, Asian physicians, to organize and serve those inner-city populations, or populations that will be inclined to feel comfortable with the service that these particular physicians are rendering.

Does it limit the service to one community over another? Absolutely not. But what it does say is that these kinds of PPOs in particular give comfort level to the consumer, if you will, and reinforces the key element of good service.

We must also be fiscally responsible, and I think a utilization review. Which our patient bill of rights agrees to, is worth having so that we can review the medical decisions of practitioners. What do they need most? What helps them serve their patients best?

I think it is extremely important that we give the consumer a right to a process of grievance. Patients voice their concerns about the quality of care, and an outside process that allows that matter to be handled even before any court action is necessary. Sometimes these processes need to be done so that they are working internally and without a court structure.

□ 2015

Certainly, we would want to have what I call the antigag and provider incentive plans. Consumers have a right to know all of their treatment options. Again, that goes back to the key element of a sense of confidence, breaking the fear, not having a zip mouth in the physician's office, because I do not want to ask this question. He or she said I only have 15 minutes, and maybe they will cancel my health insurance if I ask too many questions. We need to lay down the options. There should be no bell ringing, to say now your time is up and one certainly cannot be engaged in this decision of wanting to know more treatment options, and that is it. Take it or leave it.

So I believe that it is now time that we have the right kind of HMOs and therefore, it is extremely important that we get off the dime, if you will, and really respond to what Americans are talking about, is an unentangled, caring health system that allows the best and the brightest of our health professionals to do their thing.

As I see my colleague who has joined me who has been a real leader on these issues; in fact, he might be called Mr. Health Care, because it has not just been reforming this HMO revolution. Whenever there is a revolution, we get excited and it is a new toy to play with, but sometimes we have to go in and direct the revolution. But my colleague was there on the Medicare fight when we thought a number of our seniors would be denied care, he was there on the Medicaid fight, and each step of the way we have seen a better system come about.

So for all of those people now hovering in the corner on the patient's Bill of Rights, hold your calmness and listen to what we are saying, that it is of great necessity that we open the doors to patients so that patients might feel that the system works for them.

With that, I would like to say to the gentleman from New Jersey (Mr. PALLONE) let me thank him for organizing this Special Order and allowing me to share with you what I think has to be one of the most important issues that we really need to face in the next 30 to 60 days. Somebody might say this year or over the next 2 years. I think we have a crisis that we have to deal with, and we need to pass the patient Bill of Rights that deals with HMO reform. I yield to the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, I wanted to thank the gentlewoman for being here tonight. I think the gentlewoman is the one that organized this Special Order, but I thank my colleague for saying that.

Ms. JACKSON-LEE of Texas. Mr. Speaker, we shared in it.

Mr. PALLONE. Mr. Speaker, I know that the gentlewoman has been on the floor before talking about this issue and many other health issues that the Democrats have tried very hard to bring forth in the House of Representatives.

One of the concerns that I expressed today earlier in the day when there was a resolution that the Republicans brought up with regard to President Clinton's health care task force, and they were criticizing that, and they brought up some procedural matter related to it. I took to the floor at the time because I wanted to express my concern that we not waste our time here in the House of Representatives dealing with procedural matters about who had a task force and who paid for the task force and what happened with the task force, but rather, we spend our time on substantive ways to try to achieve health care reform.

We know that there are about 40 million Americans now that have no health insurance, and we know that there are problems with managed care and with HMOs, quality problems, which the gentlewoman talked about when she talked about the Patient Protection Act and the consumer protections that we all feel should be addressed with regard to HMOs and managed care reform.

All I wanted to say today, and I will say it again this evening, and I am sure both of us are going to be saying it a lot more over the next few months to the Republican leadership, because they control the floor and what measures come up and what bills pass, and let us bring up these health care reform issues, let us bring up the patient Bill of Rights so we can reform managed care and HMOs. The President, when he spoke in his State of the Union address the other night, was very clear that a major priority for him was managed care reform and the patient protection concerns that the gentlewoman talked about. The public overwhelmingly, not only the Congressmen and women in the room, but the public in general overwhelmingly said that that was a high priority for

them. But it is not going to come up and be debated on this floor unless the Republican leadership allows that to take place.

One of the concerns I had today, and that is what this chart is, and I am not going to dwell on it, because we talked about it a lot today, but there is a concerted effort now by certain special interests to fight against the Patient Protection Act, to fight against these managed care reforms and not allow them to come forward, to move forward here in the House of Representatives. Today, the National Association of Manufacturers was actually here lobbying Members and telling the Republican leadership and getting them to go along with this idea of fighting against managed care reform.

What we have up here, I will just mention it briefly, this is a blow-up of a memo from the staff person at the Health Insurance Association of America, the for-profit health insurance lobby, and it talks about the Speaker's aides calling up lobbyists to Capitol Hill and giving them marching orders to trash the bill providing consumer protections in HMOs. I think one of the most egregious things that I see where it says here the message we are getting here from House and Senate leadership is that we are in a war and need to start fighting like we are in a war. Well, the reason we are in a war is because we know and the President knows and the Democrats know that people want managed care reform, they want these patient protections, so the war is to fight against that. They are talking about the war because they know that there is so much support for it.

Then later on, I think it is Senator LOTT, who is the majority leader in the Senate, he said that the Senate Republicans need a lot of help from their friends on the outside, and he says that they should get off their butts, I hate to use that expression, and get off their wallets, reference obviously to the need to finance and provide money, if you will, for campaigns and special interest money, if you will, to support those who fight against the health care and the patient protection reforms.

So we have a battle here. I think the gentlewoman and I said the other day that this is going to be a battle. Well, the Republican leadership claims it is a war. Whether it is a battle or a war, I do not know, but we have our work cut out for us.

But I wanted to mention very briefly if I could, there were a group of family and health care advocates, organizations that are in favor of these patient protections and the managed care reform.

Ms. JACKSON-LEE of Texas. Absolutely.

Mr. PALLONE. And they sent a letter to Members today, Members of Congress, because they knew that the National Association of Manufacturers was coming down here and lobbying against this managed care reform. So they sent a letter, and this is from Families USA, American Federation of Teachers, United Church of Christ, Women's Legal Defense Fund, AFL-CIO, a number of groups that are involved in this.

They said to the Members in their letter, when these people come that are against these managed care reforms and they come to your office today, why do you not just go through the checklist that we will provide you of what this managed care reform does and ask them whether or not—why these are bad things, why they are against these things. If I could just briefly, I have the other chart here, go through this. I know the gentlewoman mentioned a lot of these things earlier today. But I think it is very interesting to sort of pose the question in that way.

Ms. JACKSON-LEE of Texas. Absolutely. If the gentleman will yield just for a moment, it is interesting, and the checklist is important, that this group would want to go up against 88 percent of the American public that wants a consumer protection bill as it relates to health care. They want a patient Bill of Rights.

So the war is on. I think the clarion call is for the 88 percent of the American public to stand up and say what they want loudly and clearly. I think they can overcome any of those who would want to detract away from what they need, and of course that checklist will be the real test as to whether or not these folks who are opposed to it even know what they are opposed to: Simple, basic assurances, if you will, that we in this country believe that everyone should have access to good health care. I yield to the gentleman.

Mr. PALLONE. Mr. Speaker, the reason I would like to go through it quickly together, if the gentlewoman would like, is because a lot of times I worry that we deal in abstracts. Even when we talk about patient Bill of Rights, I am not sure that the public necessarily understands what we are talking about.

The great thing about debating this issue of managed care reform and the patient Bill of Rights is that when one sees what we are actually talking about, and then one hears the stories about people who do not have these benefits, then the public becomes even more aware of why it is necessary.

The first one says that health care consumers can appeal denials or limitations of care to an external, independent entity. I have had a lot of my constituents, in other words, they seek certain care, they want to stay in the hospital a couple of extra days, they want to see a certain specialist, they want to use a certain kind of equipment for a particular medical procedure, and they are either denied or they are told well, we have to go and it has to be reviewed by a certain party. What we are saying here is that if it is denied or limitations are put on a procedure or access to a doctor, that there has to be some way of externally independently reviewing that decision and overturning it in a quick fashion. Obviously, that is very important.

The second thing is, consumers can see specialists when needed. Again, I think one of the biggest problems with HMOs is the fact that increasingly, the gatekeeper, whoever it is, whether it is the primary care physician or more often some bureaucrat with the insurance company that says that one cannot see a specialist, and people need that type of specialty care, so this is an issue.

The third thing is that women have direct access to OB-GYN services. Another one is the physician decides how long patients stay in the hospital after surgery. That I think is so crucial. We had this with the drive-through deliveries where women were released from the hospital the same day that they had a child; people that had C-sections were allowed to stay only 2 days in the hospital, and the bottom line is that that decision about how long one stays in the hospital at a particular time after surgery, that should be made by the physician, in cooperation with the patient, not by the insurance company.

Health care professionals are not financially rewarded for limiting care. This is the biggest problem that we face. Increasingly, the doctors and the method of payment they receive is dependent on them putting limits on how they care for patients and what kind of care patients receive. How could one possibly have quality health care with those kinds of limitations? It is okay to say, for a doctor to say, okay, this is the number of days that you should have for this particular activity, or this particular surgery, but to have there be a financial incentive for the doctor to do that I think opens the door to abuse, and this is what we keep hearing over and over again is occurring.

Then, consumers can see my provider if the providers in their plan do not meet their needs. Again, in many cases where the HMO does not have the specialist or even does not have certain types of hospital facilities that are covered by the plan, well, if they are not covered by the plan, if someone needs a certain type of care or a certain type of specialization, they should be able to have access to it if the plan does not cover it as part of their network. That is essentially what we are saying.

Then, consumers have access to an independent consumer assistance program to help them choose plans and understand programs. This is the ombudsman concept. What I find more and more is that the average person does not even know what their plan consists of. They do not know what is in it, they do not know what is covered, they do not know what care they are allowed to have, because there is no requirement in many States for any kind of disclosure when one enters into one of these networks, one of these HMOs,

and obviously, it would be a good idea to have someone to go to to provide that kind of assistance.

Then we have health plans demonstrate that they have inadequate number mix and distribution of health care providers to meet consumer needs. Consumers get information on plans including how many people drop out of the program each year, amounts of premium dollars spent on medical care and how providers are paid, just basic disclosure. People should know what they are getting into.

Finally, this is just of course the most important aspects, is that doctors, nurses and other health care workers can speak freely to their patients about treatment options and quality problems without retaliation from HMOs, insurance companies, hospitals, and others. I think the gentlewoman mentioned before about the gag rule and how we have to eliminate that as well.

This is what we are talking about. This is not any abstract science here. It is just simple things that I think most people probably think that they are getting until they actually find out that the HMO or the managed care plan does not provide it and has these limitations. We get this out to the American public, people understand this. That is why better than 80 percent of the people support these kinds of managed care reforms.

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Ms. JACKSON-LEE. Mr. Speaker, I keep raising the 88 percent, because the gentleman is right. If we get the message out as to the Patient Bill of Rights, it is not even out the way it should be, because, as the gentleman has said, the Republican leadership has not yet seen the wisdom of getting it on the floor of the House.

Can my colleague imagine if the American public saw the value of what we were offering and realized in many instances that they did not have those privileges if they had a crisis or real health need? The good thing about what happens in this country is that as many sick people as we have, we have a lot of well people who pay for health insurance and never have the real opportunity, which is very fortunate, to maybe have a serious illness.

Of course, as we age, there are times when we do have, through age, serious illnesses. But, in fact, these persons who are in their prime of working do not have major illnesses and, therefore, are not even aware that there are limits on the kind of treatment that they might be able to get that maybe someone who has children who are all 10 and 12 did not come through the time when in 24 hours you had to be out.

Just think as we educated individuals how they would want the numbers or the numbers would show 100 percent supporting this. If we emphasized the drama of what occurred today. Leader GEPHARDT indicated a ''fly-in'' of the friends of our colleagues to swat down any kind of interest in the Patient Bill of Rights. If we could just have the American public see a swarm of bees swarming in to just stop it in its tracks, I would say we would have 120 percent because health is such a sacred part of the quality of life and what we have come to expect in this country.

I cannot imagine why this would not be a bipartisan effort to really run to support the Patient Bill of Rights, because, in doing so, we would be responding to what all of America would want, irrespective of whether or not they are Democrat, Republican, Independent. They clearly want to be able to count on their health plan.

So the gentleman has highlighted several of the major points. I had the opportunity to emphasize some of the other aspects. And it is quite extensive, but it is not redundant, it is not costly, it is certainly recognizing that what we have is a broken system.

We started out with it. It was new. We organized it in a manner that had more of a dominance of the insurance companies as opposed to the health care providers. We see that is wrong; and so we are now going back to fixing, which is a good concept. But the wrong direction. The head is not leading. The tail is leading. I think we need to get it in order so that the health care of this country can be what we would like it to be.

Mr. PALLONE. Mr. Speaker, and I know we only have a couple of minutes left, and I just wanted to say that I know what some of the arguments are that are coming from the opponents. They are saying that it will cost too much. Well, most of these things do not cost anything; and if there is a slight cost from some of them, it is so slight in terms of the benefits that a person is receiving that I think overwhelmingly people would support these patient protections.

The other thing, of course, we hear is that the Democrats, they are trying to move towards national health insurance or socialism. The reason HMOs have become so predominant in the insurance market is basically through the capitalist system. This is not the government. They have actually worked and they have competed and a lot of people have joined them, a majority of people have joined them, but we know that there are times when the system gets out of hand and the government has to step in with some modest restrictions.

These are modest restrictions. That is all we are talking about. This is not major tinkering with the system. HMOs will still be out there, and managed care will still be out there. They can still compete, but we are saying that these basic provisions have to be met to provide some semblance of quality health care.

Mr. Speaker, I yield back to the gentlewoman, because she, in fact, organized this special order this evening. But I thank the gentlewoman for having me participate in it.

Ms. JACKSON LEE. Mr. Speaker, it was certainly my pleasure. And, as we close, I certainly want to thank the Speaker for this time. I think this was an important discussion on the floor of the House, and I am delighted to have the gentleman from New Jersey join on the kinds of issues that we will be facing. We have a plan. Our task force has a plan. It is certainly appropriate for the leadership to move forward on this issue of good health care.

THE AMERICAN WORKER AT A CROSSROADS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentleman from Michigan (Mr. HOEKSTRA) is recognized for 60 minutes as the designee of the Majority Leader.

CONGRATULATIONS TO THE CONGREGATION OF GRAAFSCHAP CHRISTIAN REFORMED CHURCH ON THEIR 150TH ANNIVERSARY

Mr. HOEKSTRA. Mr. Speaker, to begin with tonight, I rise today to recognize the congregation of the Graafschap Christian Reformed Church of Graafschap, Michigan, as they celebrate 150 years of service to God, family, and their community.

On April 4, 1847, 14 pioneers left Rotterdam, the Netherlands, with the hope of finding religious freedom and economic opportunity in America. They arrived in New York harbor on May 23 and settled on the south shore of Macatawa beach in Holland, Michigan, on June 20.

The settlers soon founded the Graafschap Christian Reformed Church, dedicating their first log church in 1848. As Graafschap Christian Reformed Church grew in numbers and strengthened her spiritual roots, its vision expanded beyond its own congregation and extended into its community. In the past 150 years, the church has been a strong supporter of Christian education. As a leader in community ministry, the congregation has supported and participated in mission projects around the world.

The past and present members of the Graafschap Christian Reformed Church have had a profound impact on the Holland, Michigan, area. Now with more than 500 members, the church is dedicated to continuing its spiritual mission far into the future.

I would like to extend my thanks to Graafschap Christian Reformed Church for 150 years of service and commitment to God and the community, and offer my congratulations on the celebration of their anniversary. May God continue to bless the congregation and their work in the years to come.

THE AMERICAN WORKER AT A CROSSROADS

Mr. Speaker, I would like now to move on to another topic, a topic that I feel very strongly about and that I have a high degree of interest in. The project is called the American Worker at a Crossroads, because I think we recognize that the American worker is at the heart of our economy. It is not