year, but I think that put the walls up on the economy. It was a tough budget. Admittedly, I did not support all of that budget. I had my differences, particularly on the spending side, but it passed.

Then we go on to the 1997 balanced budget agreement, and that budget also took bipartisan support. One would think from the rhetoric on the other side of the aisle that this was all done with Republican support, but only 187 Republicans supported it. I should not say only. I give them tremendous credit for being 187 to pass that budget, but it took 31 Democrats to stand up for that one, too; and not everybody has been happy with that budget, but that is the history.

When we start talking about the budget for this year, the Blue Dogs have been suggesting the 50/25/25 solution all year long. Take all of Social Security off budget. Take the remaining surplus projected and half of it pay down the debt and divide the other half equally between spending and tax cuts. We have 177 votes for our budget. That is not enough. 140 Democrats support it. Only 37 Republicans support it, but I appreciate the 37 and the 140.

That brings us to where we are today. It is interesting today, because, again, one listens to the rhetoric, I am reading from the Congressional Daily today. Senator LOTT said we know the fiscal year 2001 surplus will be $240 billion to $250 billion. We do not know what the surplus will be in 6 years. Exactly. That is the point some of us have been trying to make. That is why some of us have cast some very difficult votes regarding the death tax, regarding the marriage tax penalty.

We have said let us fix those two problems the best we can. In the case of the death tax, let us make sure that no estate of $4 million and less will ever have to deal with the confiscatory, sometimes downright, what I would consider, almost criminal confiscation of property of small businesses. We can do that, and the President will sign that. It does not take $105 billion, and it does not take leaving a black hole in 2010 for Social Security, which is my primary objection to that bill that is no longer on the table.

The Concord Coalition has some good ideas. In deciding the future of discretionary spending caps, policymakers must balance four major objectives: adequate funding for national priorities. We can find some bipartisan support for determining that number, and we can put some new caps into place that we can certainly live with for the next 5 years. They have to have some political reality. We cannot come on the one hand and spend all of it on a tax cut before we get into the priority spending and we have to get honesty in budgeting. I think the Concord Coalition is on to something, as they usually are, because they are bipartisan in nature. They avoid the partisan rhetoric that often flows around this body, particularly in those years divisible by two.

Let me just say kind of in conclusion, I believe the gentleman from Iowa (Mr. GANSKE) is here and I do not want to take the entire hour today. I was expecting some other colleagues to join me, but they are not here. Let me just say that let us not get too carried away with this new budget that has been offered by the leadership of this body to suggest that 90 percent solution.

Mr. Speaker, it does not add up. It just does not add up, and it is time for us to realize that we cannot go an entire year on a game plan of saying that the most important thing we need in this country is a tax cut and then find out we cannot pass it because we should not pass it, and then all of a sudden flip to a new budget that does not add up. Neither one has added up, but there is still support on this side of the aisle, and we would be surprised how much bipartisan cooperation we could get if we just acknowledged that the $4.6 trillion surplus that is projected is not real and should not be spent as real money.

PATIENT PROTECTION LEGISLATION AS IT RELATES TO HEALTH MAINTENANCE ORGANIZATIONS

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

Mr. GANSKE. Mr. Speaker, I thank the gentleman from Texas (Mr. STENHOLM) for yielding a little earlier this evening. Just as a form of notice to the next speaker, I will probably speak somewhere between 20 and 30 minutes.

Mr. Speaker, I want to talk tonight about a topic that I have come to the floor many, many times in the last several years to speak about, and that is on the issue of patient protection legislation as it relates to health maintenance organizations, HMOs.

Mr. Speaker, I remember a few years ago, it must be about 4 years, that my wife and I went to a movie called As Good as It Gets. We were in Des Moines, Iowa, at a theater and I saw something happen that I do not think I have ever seen at a theater. During that scene, when Helen Hunt talks to Jack Nicholson about the type of care that her son in the movie, with asthma, was getting from her HMO and she uses some rather spicy language that I cannot say here on the floor of the House of Representatives, people stood up and clapped and applauded in that movie theater. I do not think I have ever seen that before.

□ 1900

Mr. Speaker, that was an indication 4 years ago that there was a problem with the type of care that HMOs were delivering. Then, Mr. Speaker, we began to see the problems that patients were having with HMOs captured in political cartoons. Things like cartoons in the New Yorker Magazine. Here was one. This is pretty black humor. We have a secretary at an HMO, and she is saying ''Cuddly care HMO. My name is Bambi. How may I help you?''

Next one, ''You are at the emergency room and your husband needs approval for treatment.'' Next one, ''Gasping, writhing, eyes rolled back in his head does not sound all that serious to me. Clutching his throat, turning purple. Um-hum?'' And she says here, ''Have you tried an inhaler?'' She is listening on the phone. ''He is dead. Then he certainly does not need treatment, does he?'' And the last picture there on the lower left shows the HMO bureaucrat saying ''People are always trying to rip us off.''

For years now we have seen headlines like this one from the New York Post, ''What his parent did not know about HMOs may have killed this baby.''

Here is another cartoon. This is the HMO claims department, HMO medical reviewer with the headphone set on is saying, ''No. We do not authorize that specialist. No. We do not cover that operation. No. We do not pay for that medication.'' Then apparently the patient must have said something, because all of a sudden the medical reviewer at that HMO kind of sits up and then angrily says, ''No. We do not consider this assisted suicide.''

Or how about this headline from the New York Post, ''HMO's cruel rules leave her dying for the doc she needs.'' Pretty sensational headlines.

And then we had this cartoonist's view of the operating room, where you have the doctor operating. You have an anesthesiologist at the head of the table and then you have an HMO bean counter. The doctor says, ''Scalpel.'' The HMO bean counter says, ''Pocket knife.'' The doctor says, ''Suture.'' The HMO bean counter says, ''Band-Aid.'' The doctor says, ''Let us get him to the intensive care.'' The HMO bean counter says, ''Call a cab.''

Some of these I think have passed the realm of being even humorous, because it has just been going on too long. You notice you do not see Jay Leno or David Letterman talking much any more about HMOs. It has just gone on too long. People are being hurt every day by capricious rules that deny people medically necessary care by HMOs; and patients have lost their lives because of it.

Here are some real-life examples. This woman was hiking in the mountains west of Washington, D.C., in Virginia. She fell off a 40-foot cliff. She fractured her skull. She broke her arm. She had a broken pelvis. She is laying there at the bottom of this 40-foot cliff. Fortunately, her boyfriend had a cellular phone. So they flew in a helicopter. They strapped her on, flew her to the emergency room. She was in the ICU, there for weeks on intravenous morphine for the pain.

And then a funny thing happened, when she finally got out of the hospital, she found out that her HMO refused to pay the bill. Why, you ask.

Well, the HMO said that she did not phone ahead for prior authorization.

Now, I ask you something, this lady's name is Jackie, how was Jackie supposed to know that she was going to fall off that cliff, then maybe when she is lying at the bottom of that cliff semicomatose she is supposed to have the presence of mind with her nonbroken arm to reach into her coat pocket and pull out a cellular phone and dial an 1–800 HMO number and say I just fell off a 40-foot cliff, I need to go to an emergency room, is that okay? Maybe when she is in the ICU for a week on intravenous morphine, she is supposed to have the presence of mind to phone the HMO? Real life story.

How about this woman in the center? This woman's case was profiled on a cover story on Time magazine 2 years ago, maybe it was 3 years ago now. Her HMO denied her medically necessary care, and she died. Now, her little boy and her little girl do not have a mother and her husband does not have a wife.

Before coming to Congress, I was a reconstructive surgeon. I took care of babies that were born with this type of birth defect, a cleft lip and a cleft palate. Do you know that more than 50 percent of the surgeons who repair these types of birth defects have had HMOs deny operations for repairs related to this defect, because HMOs have said that that is a ''cosmetic defect''?

Just imagine that you were the parents of a baby born with this defect, number one, the baby is not going to learn how to speak normally, because there is a hole in the roof of the mouth. Food is going to come out of the nose. Is that a cosmetic problem? Is speech a cosmetic problem? Not that I ever heard of. I happen to think it is a human right. It is a devine right to look human, and I think it is just absolutely wrong for HMOs to do what they do to kids who are born with birth defects, many times worse than this.

Let me tell you about this little baby boy. His name is James. When he was 6 months old, about 3:00 in the morning, his mother found that he was really sick, and he had a temperature of about 105. She asked her husband what they should do, and they said well, we better phone that HMO that we belong to. They phoned the 1–800 number talked to a member a thousand miles away, explained how sick their baby was, and that voice at the end of the line, who never examined this baby to see how sick he was, said, well, I will authorize you to go to an emergency room, but we only have a contract with one, so we are only going to let you go to that one, that is it.

Well, mom and dad are not medical professionals, so they hop in the car. Unfortunately, that authorized hospital was more than 60 miles away, 60 miles away, clear on the other side of metropolitan Atlanta, Georgia. En route mom and dad passed three emergency rooms that they could have stopped at.

They knew Jimmy was sick. They were not medical professionals. They did not stop because they knew if they did it without authorization, they would be left with a bill. Unfortunately, before they got to the authorized hospital, Jimmy had a cardiac arrest. Imagine you holding little Jimmy trying to keep him alive while you are trying to find that distant emergency room. Finally, when they pull in to the hospital emergency room, mom throws open the door, leaps out, screaming, help my baby, help my baby, a nurse comes running out, resuscitated Jimmy.

They put in lines. They give him medicines. They get him going. They save his life. Unfortunately, because of that delay in medically necessary treatment, they cannot save all of Jimmy because gangrene sets in in his hands and his feet, and little Jimmy's hands and his legs have to be amputated. That HMO made a medical decision, instead of saying it sounds like he is sick, take him to the nearest emergency room, it is okay with us, we will pay for it. They said, no, no, we only authorize you going to that far away hospital.

Mr. Speaker, little Jimmy is going to live all the rest of his life with bilateral hooks for hands, with protheses for legs. He is about 7 years old now. In fact, I brought him to the floor of this House of Representatives during our debate on patient protection legislation almost a year ago, and he is a great kid. He is doing good. He has got good folks, but I will tell you what, he is never going to play basketball, and he is never going to touch with his hand the cheek of the woman that he loves, and that HMO should be responsible for that decision.

Unfortunately, there is a Federal law, a 25-year-old Federal law called the Employee Retirement Income Security Act. It was really written to be a pension law, but it was applied to health plans. And what it did was it took away oversight of health insurance from the States for people who get their insurance through their employer, and it did not institute any of the safeguards for quality control to prevent the types of problems like little Jimmy had, that your State insurance commissioners normally do. It left a vacuum.

Furthermore, it said that the only liability that that health plan would have would be the cost of treatment denied, the cost of treatment denied. That means that if little Jimmy is in an employer-sponsored health plan, a self-insured plan, the only thing that that health plan is liable for is the costs of his amputations. What about all the rest of his life? Is that fair? Is that just? I do not think so. Neither does the Federal judicial, neither do the Federal judges whose hands are tied, because of this law called ERISA.

Judge Gorton in Turner v. Fallon Community Health Plan said even more disturbing to this court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

I have had Federal judges tell me, beg me to change that Federal law; number one, they think that these types of medical malpractice decisions should be handled in the State courts, like they are for anyone else. Number two, they realized that because of provisions in that law, they cannot even address the issue of the health plan defining medical necessity in any way they want to.

What does that mean? Well, under the ERISA law, a health plan can write a contract for the employees that basically says we are not liable for anything if we follow our own definition of what we consider to be medically necessary. So they can write a provision in the contract for an employee, for you, that would basically say we define medical necessity as the cheapest, least expensive care, quote, unquote, as determined by us.

That means that for this little boy who was born with a cleft lip and palate, instead of the traditional and optimal treatment of surgical correction utilizing the baby's own tissues to rebuild the defect, that HMO could say well, under our definition of the cheapest least expensive care, you know, just in the roof of his mouth, that big hole there, just put like an upper denture plate.

☐ 1915

It is called an obturator, made of plastic. Of course, a baby like this, it might fall out, it might even be swallowed. So what? We can do that, because we defined it, medically necessary care, as the cheapest, least expensive care. I think that is wrong. That is why judges are saying, they are begging Congress, please, please, change that law. Our hands are tied.

Well, here we are, as I said before, almost a year since we passed in this House a bipartisan vote, 275 to 151, the Norwood-Dingell-Ganske Bipartisan Consensus Managed Care Reform Act, a real patient protection act. It has been almost a year. And I will tell you what, the public's opinion has not changed one bit about HMOs.

Today in USA Today they quote from a Gallop organization poll a list of occupations or organizations that people say they have a great deal of or quite a lot of confidence in those institutions. At the top of the list is the military; 64 percent of the public have a great deal of confidence in the military. Organized religion, 5 percent of the public; the police, 54 percent; the Supreme Court, 47 percent.

Then we get down toward the bottom of the institutions. Congress is down here at 24 percent. The criminal justice system, 24 percent. This probably reflects all of the news stories on the death penalty lately. But right at the very bottom of this, of institutions

that the public respects, only 16 percent of the public thinks HMOs are deserving of respect, only 16 percent.

In fact, overwhelmingly, the public thinks that Congress should pass and the President should sign a real patient protection law, one that would do many things: one that would cover all Americans; one that would allow doctors to make medical decisions; one that would hold those HMOs accountable for their decisions; one that would guarantee minimum health plan standards; one that would allow you to appeal a decision to an independent review panel if an HMO denies your care; and one that would have that independent panel make that determination of medical necessity, not some bogus definition by the health plan. These are all things that were in our bill, the Norwood-Dingell-Ganske bill, that we passed.

Well, the Senate passed a bill too; and, unfortunately, to be honest, I would have to characterize that Senate-passed bill as an HMO protection bill, an HMO protection bill, because it actually, in my opinion, had provisions that were worse than the current situation, that gave additional protections to health maintenance organizations, rather than additional protections to patients.

After the House passed its bill and the Senate passed its bill, it went to conference to iron out differences between the bills, and that conference has not met in months. It is a failed conference, nothing has come out of it, so it is time to move; it is time to try something different.

In an effort to get patient protection legislation signed into law, the gentleman from Georgia (Mr. NORWOOD), the gentleman from Michigan (Mr. DINGELL), myself, and Senator KENNEDY have created a new discussion draft of the House-passed bill, the Norwood-Dingell-Ganske bill, that seeks compromise with Senator NICKLES' amendment; and some of the ideas of the House substitute bills from last year that did not pass.

We continue to think the original Norwood-Dingell-Ganske bill is just fine and should be signed into law, but we are willing to be flexible in order to get a law, in order to get action in the Senate. We and the American Medical Association and over 300 health care groups who supported last year's House-passed bill have developed this discussion draft to see if it would help bring some Republican Senators on board.

We have had positive responses from a number of Republican Senators, including those who have previously voted against the Norwood-Dingell bill, as well as those who have voted for the Norwood-Dingell bill. We remain optimistic that we may soon have an opportunity to break this logjam.

This discussion draft, which we have provided to the Speaker of the House along with the actual legislative language in detail, does many things. It includes many of the protections nearly all parties need to be addressed, including the right to choose your own doctor, protections against gag clauses, access to specialists, such as pediatricians and obstetricians and gynecologists, access to emergency care, so we can prevent something from happening like happened to poor little Jimmy, and access to information about the HMO's plan.

This discussion draft applies the patient protections to all plans, including ERISA plans, non-Federal Governmental plans, and those covering individuals. So we cover over 190 million Americans. This new draft addresses the concerns of those who want to protect States' rights by allowing States to demonstrate that their insurance laws are at least substantially equivalent to the new Federal standards, thereby leaving the State law in effect. State officials could enforce the patient protections of State law. The Secretary of Labor and Health and Human Services can approve the State plan or challenge it on grounds that it is inadequate.

Under the new draft, doctors will make medical decisions involving medical necessity. When a plan denies coverage, the patient has the ability to pursue an independent review of the decision from a panel independent of the HMO. This external review is composed of medical professionals totally independent of the plan and whose final medical necessity decision is legally binding on the plan.

We took the lead from the Nation's courts with particular attention given to the Supreme Court's decision in Pegram v. Hedrick. The new draft reflects emerging judicial consensus. Recent court decisions have suggested injured patients can hold health plans accountable in State court in disputes over the quality of medical care, those involving medical necessity decisions. However, patients would have to hold health plans accountable in Federal court if they wanted to challenge an administrative decision to deny benefits or coverage or for any decision not involving medical necessity.

In addition to specific legislative provisions, the discussion draft, this discussion draft, answers continuing questions about the original Norwood-Dingell-Ganske bill. For instance, the draft says employers may not be held liable unless they ''directly participate'' in a decision to deny benefits as a result of which a patient was injured or killed. Even then defendants could not be required to pay punitive damages unless they showed ''willful or wanton disregard for the rights or safety'' of patients.

Another concern about the Norwood-Dingell-Ganske bill was whether it would affect the ability of health plans to maintain uniformity in different States. This new draft only subjects plans to State law when they make medical decisions that result in harm. This discussion draft will allow Republican Senators who have voted against the original Norwood-Dingell bill to vote for a real patient protection bill. Will they take up this opportunity? Stay tuned. But time is running out. People are waiting to see whether this Congress will actually deal with one of the major health concerns that the public has. Eighty-five percent-plus of the public thinks Congress should pass patient protection legislation to protect them from HMO abuses, 85 percent. About 75 percent think that that should include legal responsibility for the HMOs.

If this bill, this discussion draft, is ignored, then I am sure we are going to see this as one of the major issues in the coming election, and we should, and we should. We have been working on this legislation now, the gentleman from Georgia (Mr. NORWOOD), the gentleman from Michigan (Mr. DINGELL), SENATOR KENNEDY and others, for about 4 years.

When I am back home in the district people say, Why is it taking you so long to get something passed that the public overwhelmingly wants? I tell them we are fighting a very, very powerful industry that has spent $100 million lobbying against this piece of legislation, some very, very powerful Washington special interests, who are seeking to, in my opinion, make sure that their bottom line profits come ahead of patient protections.

Well, we will see whether we get this done. There are not too many more weeks when I will be able to come to the floor and speak about this issue, but as long as we are in session for the rest of this year, I will try to get an opportunity to inform my colleagues on where we stand. But I wanted my colleagues on both sides of the aisle to know that the Republicans and the Democrats who truly want a real patient protection piece of legislation are working together.

We have never said, along with the 300-plus consumer groups and professional groups that think that this legislation should pass too, we have never said it has to be the Norwood-Dingell-Ganske bill word for word. That is why we have come up with this discussion draft. That is why the language for many of these provisions is taken from the Nickles amendment, the Coburn-Shadegg amendment and others, at least half of the language. We have made some adjustments to correct some of the defects as we see it in some of those provisions, but we have been willing to work towards a compromise to finally get this signed into law. We are this close. It would be a shame for the leadership of Congress to hold this important piece of legislation up.

As a physician who has taken care of patients who have had a lot of troubles with HMOs, I have been on the front line; and I have seen that we truly need this type of legislation.

This is not a piece of legislation for physicians. In fact, there are provisions in our bill that could actually decrease

physician income. Nevertheless, the professional groups support this. Why? Because their first and foremost job is to stand up for and to advocate for their patients. That is why they take that Hippocratic Oath.

□ 1930

The patient-doctor relationship is foremost. HMOs have interposed themselves between the doctor and the patient. Quite frankly, they have put a financial consideration rather than the patient's best care into that decision-making. Mr. Speaker, we need to swing that pendulum back.

Now, this brings me, finally, and I just would like my colleagues from the other side to know that I only have a few more minutes in which to speak; this brings me to another health care issue, and that is that when we passed the Balanced Budget Act in 1997, we passed several provisions on reducing the rate of growth in Medicare. The implementation of those provisions has actually produced significantly more savings than we planned on, and those savings have had a significantly harmful effect on some of the provider groups.

Mr. Speaker, I just finished a series of town hall meetings around my district. I represent Des Moines, which is a major metropolitan suburban area, but I also represent southwest rural Iowa. There are a lot of small town county hospitals in my district. Because of certain provisions from the Balanced Budget Act with reduced payments to those hospitals, those hospitals are having a real hard time and are right on the verge of financial insolvency.

I grew up in a small town in northeast Iowa. I know how important it is that a small town have a hospital. It is important for a number of reasons. It is important for the people who live in that town or the farm families around it so that they do not have to travel 70 or 80 miles if they have a heart attack or if they want to deliver a baby, but it is also very important to the financial survival of that small town. If we do not have a hospital in that small town, it is hard to keep doctors in the town. If we do not have a hospital and doctors in that town, it is hard to keep businesses in that town, and it is almost impossible to convince any other business development in that community. So we are talking about not only an issue of public health, but we are also talking about an issue of economic survival.

My committee, the Committee on Commerce, is in the process, along with the Committee on Ways and Means, of drawing up a bill to bring some additional funds back into Medicare. I am working hard to ensure that we get some additional funding for those small towns and rural hospitals in Iowa and in other areas around the country. There will be discussion on whether we should provide additional payments to Medicare HMOs. I think we need to be careful on doing that.

Mr. Speaker, I have here a Report to Congressional Requesters from the United States General Accounting Office on Medicare Plus Choice. It is Entitled Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending, and it is dated August 2000, and it was requested by Senator GRASSLEY, by Senator ROTH, by the gentleman from Michigan (Mr. DINGELL), and by the gentleman from California (Mr. THOMAS). I think it is really important for me to read the summary, the results, in brief:

''Medicare Plus Choice,'' this is a quote from this GAO report:

Like its predecessor managed care program, has not been successful in achieving Medicare savings. Medicare Plus Choice plans attracted a disproportionate selection of healthier and less expensive beneficiaries relative to traditional fee-for-service Medicare, a phenomenon known as favorable selection, while payment rates largely continue to reflect the expected fee-for-service costs of beneficiaries in average health. Consequently, in 1998, we estimated that the program spent about $3.2 billion or 13.2 percent more on health plan enrollees than if they had received services through traditional fee-for-service Medicare. This year, the Health Care Financing Administration implemented a new methodology to adjust payments for beneficiary health status. However, our results suggest that this new methodology, which will be phased in over several years, may ultimately remove less than half of the excess payments caused by favorable selection. In addition, the combination of spending forecast errors built into the plan payment rates and the Balanced Budget Act payment provisions cost an additional $2 billion, or 8 percent in excess payments to plans instead of paying less for health plan enrollees. We estimate that aggregate payments to Medicare Plus Choice plans in 1998 were about $5.2 billion, or approximately $1,000 per enrollees more than if the plan's enrollees had received care in the traditional fee-for-service program. It is largely these excess payments, and not managed care efficiencies, that enable plans to attract beneficiaries by offering a benefit package that is more comprehensive than the one available to fee-for-service beneficiaries while charging modest or no premiums.

Mr. Speaker, this brings us directly to the issue of prescription drug coverage. Because what this is saying is that number one, the Medicare HMOs have been skimming off the healthier beneficiaries so that they would have lower costs. That way they make more money on covering those. They are getting paid more for those Medicare beneficiaries than if those beneficiaries were simply in the regular Medicare plan. With those excess profits, what they do is they can entice other healthier seniors into it by offering a prescription drug benefit. I think as we consider whether and how Congress should implement a prescription drug benefit, we need to take into account this GAO report that documents that we have actually lost money with our Medicare HMOs, rather than saved money with our Medicare HMOs.

So when we look at this Medicare give-back bill that is coming along and will be signed into law, passed and signed into law, I am pretty sure, I think we ought to be very careful and judicious about providing more money to those Medicare HMOs. We ought to be looking, in my opinion, at ways to provide pharmaceutical coverage, a prescription drug benefit for Medicare beneficiaries, regardless of whether they live in New York or Los Angeles or Miami or Harlan, Iowa. That benefit I think should be equally available, regardless of where one lives in this country. If we dump additional billions into a failed HMO program called Medicare Plus Choice, then I think we will be throwing money down the drain.

So clearly, this will be a package of provisions, and I absolutely feel that it is important to support provisions for additional coverage for our rural hospitals, for example, but I will also do my best to try to make sure that we do not go overboard with providing additional funds to Medicare HMOs, when this report from the GAO shows that even with the implementation of a new risk adjuster, we will still only take care of 50 percent of the excess payments.

Well, Mr. Speaker, I very much appreciate the opportunity to speak tonight on health care issues, and I look forward to working with my leadership and with members on both sides of the aisle to try to get adjustments made for Medicare for our rural hospitals and to get finally signed into law a real patient protection bill modeled along the lines of what we passed here in the House almost a year ago, the Norwood-Dingell-Ganske bipartisan consensus Managed Care Reform Act.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. GILCHREST (at the request of Mr. ARMEY) for today on account of family matters.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. MCNULTY) to revise and extend their remarks and include extraneous material:)

Mr. HOLT, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

Mr. INSLEE, for 5 minutes, today.

Mr. PASCRELL, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. GREEN of Texas, for 5 minutes, today.

Mr. FARR of California, for 5 minutes, today.

(The following Members (at the request of Mr. DUNCAN) to revise and extend their remarks and include extraneous material:)

Mr. MCCOLLUM, for 5 minutes, today and September 19 and 20.