

But this week I am introducing a bill that I hope will make some small contribution to addressing a problem that I and other people have been talking about for many years. It is a problem that the recent episodes of school violence in Colorado and Georgia and other places around the country have once again brought to the forefront of our national debate. It is the problem that my colleague Dr. BAIRD was talking about.

Our schools are too big and too impersonal. Too many of our children wake up every day and go to schools that make them feel disconnected and detached from their teachers, their parents and their communities. The goal of my bill that I am introducing, the Smaller Schools Stronger Communities Act, is to make our schools smaller and to help parents, teachers and administrators and students strengthen the sense of community that many of our schools today are lacking.

My strong feelings about this issue come from my own experience growing up in southern Indiana. When I was growing up in Jackson County, there were more high schools than there are today in towns like Tampico and Clear Spring and Cortland. There were high schools that local kids attended and local families supported. These communities were proud of their schools. Their schools brought people together and helped keep their towns strong and vital places to live.

These schools were the hearts of the communities, and when we consolidated, when school consolidation forced their high schools to close, it tore the heart out of these communities. These high schools along with thousands of other smaller schools around America were closed because for many years educators have followed the rule that bigger schools are better. For a long time we all assumed that bigger schools were better because they could offer students more courses, more extracurricular activities, and could save school districts money.

The statistics on school size show how dramatically this bigger-is-better approach has changed the way we educate our children. In 1930 there were 262,000 elementary, middle and high schools in America. Today there are only 88,000 schools. In 1930 the average school had 100 students. Today's average school has 500 students.

Some education experts are now arguing that school consolidation has gone too far. More and more educators today believe that our children do better academically and socially in smaller schools that are closer to their homes and their parents than in the big schools with thousands of students. Because many schools have become too big, they sometimes harm the students they are supposed to be helping. Many students in big schools never develop any meaningful relationships with their teachers and never experienced a sense of belonging in their schools.

When I start looking at the issue of big schools, I was surprised to find that some of the biggest critics of big schools are high school principals. The men and women who run our high schools, who work with our teenagers every day, say that schools are too big and too impersonal. In 1966 the national association of secondary school principals released a report criticizing the bigness of today's high schools. The principals recommended that the high school of the 21st century be much more student centered and personalized.

Here is what the high school principals said: students take more interest in school when they experience a sense of belonging. Some students cope in large impersonal high schools because they have the advantage of external motivation that allows them to transcend the disadvantage of school size. Many others, however, would benefit from a more intimate setting in which their presence could be more readily and repeatedly acknowledged. Experts have found that achievement levels in smaller schools are higher especially among children from disadvantaged backgrounds who need extra help to succeed.

A recent study of academic achievement and school size concluded that high schools and smaller schools perform better in course subjects of reading, math, history, and science. Students in smaller schools also have better attendance records, are less likely to get in fights or join gangs. A principal of a successful small high school recently wrote that small schools offer what metal detectors and guards cannot, the safety and security of being where you are well known by the people who care for you the most.

The bill that I am introducing, the Smaller School Strong Stronger Communities Act provides grants to school districts that want to develop school size reduction strategy. This bill does not introduce a new mandate or try to micromanage local education authority. It simply supports education leaders in school districts who decide they want to implement a plan to reduce the size of their school units either through new building space or through schools within schools.

I hope this bill will encourage local school districts to take a look at this idea and perhaps think about ways they can make their schools smaller and to find ways to help students feel connected again to their schools and their communities and their parents. This bill and the academic research I have been discussing here today make a very simple point about our schools, our kids, and ourselves. Our lives are better when we feel connected to the people we live and work with.

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HEALTH CARE REFORM

The SPEAKER pro tempore (Mr. WELDON of Florida). Under the Speak-

er's announced policy of January 6, 1999, the gentleman from Missouri (Mr. TALENT) is recognized for 60 minutes as the designee of the majority leader.

Mr. TALENT. Mr. Speaker, I want to talk about health care tonight, and I am going to get into some legislative language. I think it is important that we do that, because we are going to be voting tomorrow and the next day on pieces of legislation that will have as big an impact on the quality of life of the American people as anything that will be voted on this session. And I think sometimes it is important that before we vote on bills, we actually read them and take a look at what they say. I hope that comes clear in the course of my discussion this evening.

Before I get into what may sound to some people, however, like a bit of a law school discourse or exercise, I want to talk about the real impact these bills are going to have on real people.

There is nothing more important to the average American and his or her family than the quality of the health insurance that they have access to.

We need health care reform in this country, and we have to keep in mind that it has two aspects. First and foremost, we have to help people who do not have access to good quality private health insurance get access to that health insurance.

Then the second thing we have to do is ensure once they have access to that insurance, it delivers for them. When they get sick, they get the care their physician says that they need, when they need it, before they become seriously ill or before they die. But it is very important that we make certain that in providing for health care reform and providing for accountability of managed care plans, we do not increase the number of people who do not have health insurance in the first place.

Health care reform of insurance is of no value to you if you do not have the insurance, and too many people in America today do not have health care insurance. Forty-four million people in the United States do not have health insurance. One out of every six Americans is without health insurance. They face the risk of illness, they and their families, without having health insurance.

There is nothing more tragic than talking to individuals in this situation. Maybe they have been downsized by a company, they are working for a small employer who does not provide health insurance, they cannot afford it. Maybe they are 55, 60 years old, retired, but they are not old enough for Medicare. Maybe they have a history of illness and they do not work for a large employer and they cannot buy health insurance on the individual market.

These are our friends and neighbors, and we need to help them. Eleven million of them are children, and 75 percent of the people who are uninsured work for small businesses or own small

businesses, or are the dependents of people who work for or own small businesses.

That is the first thing that we need to do with health care reform. We are going to have an opportunity to do that tomorrow. We are going to have an opportunity to pass an accessibility bill that will open up health insurance to millions of people who currently do not have it, and we are going to do that with a number of things in the bill. Some of them provide tax relief to people so they can better afford health insurance on the individual market.

One important provision that I co-sponsored allows small employers to pool together in associations, the Chamber of Commerce, the Farm Bureau, the Psychologist Association. They can pool together in an association. The association can sponsor health care plans. Then the small employers can buy those plans for their employees and they can have health care, the same way big employers offer health insurance to their employees today. We are going to have an opportunity to vote on that bill tomorrow.

We are also going to have an opportunity, Mr. Speaker, to vote on the whole issue of accountability, so that, again, when people get health insurance, and that is the number one thing, we ensure that they get the care their physician prescribes when they need it, before they get seriously ill, before they die, and we do that without big government, without increasing costs in a way that increases the number of uninsured. We will have an opportunity to do that also in the next couple of days.

Now, in considering how we can hold HMOs accountable, the problem is this, and most Americans are familiar with it. The concern is maybe less what their insurance covers than the fact that when they get sick, their HMO may not provide the coverage they are supposed to provide. A lot of people have been in that situation. Other people are afraid of being in that situation.

The best thing to do about that is to give individuals and their physicians access to speedy, low cost, internal and external review before independent physicians when the plan has denied their care. So here would be an example, and I am going to use this example several times throughout this discussion, Mr. Speaker.

Let us suppose you belong to a managed care plan or you are a participant in it. You have a heart problem. Your cardiologist recommends beta blockers. That is a drug that will help clear up the arteries if they are blocked. The health care plan says no, you do not need beta blockers. More conservative treatment is appropriate.

We need to make certain that people can have access to external review procedures under those circumstances. They can appeal, in a low cost, quick, timely way, to a panel of independent specialists, cardiologists who are not

controlled by the health care plan, and those cardiologists decide whether or not that treatment is medically necessary under those circumstances.

Professionals in any field should be reviewed by other professionals and specialists in that field. We can do that. We are going to have the opportunity to vote for legislation that does that.

It may be appropriate to back that up with liability, limited kinds of liability against the health care plan, to reinforce that external review procedure. So it the plan does not go along with the decision of the independent physicians, they can be sued and they can be hammered with punitive damages under those circumstances.

What we want to avoid, Mr. Speaker, is open-ended liability against employers in particular and against labor unions, in addition to against health care plans, that will jack up the cost of health insurance by billions of dollars, moving that money out of health care and into litigation; moving people out of treatment rooms and into courtrooms.

If we pass a bill that does that, Mr. Speaker, we are going to make the problem worse instead of better, because we are going to vastly increase the number of people in the United States who are uninsured.

It is my concern that the bill being offered by my colleagues, Mr. NORWOOD and Mr. DINGELL, would do exactly that. I say this with the sincerest of respect for their passion and their dedication on this issue, but I am concerned that their bill, the Norwood-Dingell bill, opens up precisely the kind of liability that will jack up the number of uninsured in the country by moving people again out of treatment rooms and into courtrooms.

The Norwood-Dingell liability provision is open-ended liability in hundreds of State courts around the country for any result that someone claims to be negative in a health care case, if that result can be connected in any way to any aspect of the operation of any health plan, with unlimited damages, including punitive damages, for the employer, for a labor union if it is a labor-management plan, and for the employees of the employer and the labor union, and, in fact, for contractors or accountants or people associated with the employer or the labor union if they assisted in any way in setting up the health care plan. Again, it would move billions of dollars out of treatment, out of health care, into litigation. That is not good for anybody.

So much for my preface, Mr. Speaker. I want to get to the language in the Norwood-Dingell bill. It would be kind of hard to read it this way, so let me turn it around.

The Norwood-Dingell bill allows any cause of action, there it is in bold, against any person, it does not define "person," so that means the employer, it means the health care plan, it means employees of the employer or the

health care plan, for any personal injury, and they define that to mean a physical injury or a mental injury, so it cannot be an economic injury, but allows a cause of action against any person for any physical injury that is connected to or arises from, in connection with or that arises out of, the provision of insurance, the administrative services, or medical services, or the arrangement thereof.

This is not just a cause of action for the denial of a benefit. It is not just a cause of action when a health care plan goes against the treating physician or the external reviewer. It is much more broadly written than that. It could not be more broadly written. It is a cause of action for any injury arising out of or in connection with in any way the operation or arrangement of a health care plan.

Now, Mr. Speaker, I am a lawyer. When I read this language, I put my lawyer's hat on and I thought, now, what kind of lawsuits are we going to see in response to that kind of language?

Well, just a couple of what we lawyers call hypotheticals. They are hypotheticals in the sense that they have not actually happened because we have not actually passed this bill, but they are the kinds of cases that will be brought if we do pass this bill.

First the classic case. Let me go back to my beta blocker example. When physicians treat clogged arteries, they have to choose whether to use beta blockers, which is a drug or a cardiac cath, a minor surgery or some more aggressive kinds of surgery or treatment.

So, let us suppose that somebody goes to their cardiologist in a managed care plan, and the cardiologist decides to grant a cardiac cath, to prescribe a cardiac cath, and the plan reviews that decision by the treating physician and denies the cardiac cath and, as a result, some kind of injury arises.

Well, that is a physical injury arising out of the provision of medical services, so clearly a cause of action would be warranted. But let us suppose that the plan grants the treating physician's decision and allows the cardiac cath and an injury results. That too is a physical injury in connection with or arising out of the operation of a health plan and you can sue the health care plan for that.

Or let us assume the health care plan says look, we do not even want to review this. We are going to let the physicians prescribe whatever they want, and go along with that, and a bad result occurs. Then you could sue the plan for not reviewing what the physician does, and that would be a physical injury arising out of or in connection with the arrangement of a health care plan and a cause of action would lie under the Norwood-Dingell bill.

That cause of action, remember, is against any person. Not just the plan, but the employer who purchased the plan, the restaurant owner, the small restaurant owner who went out and decided he was going to try to provide

health insurance to his people and linked up with a managed care network, or a big employer with a big HR department and tries to operate these plans in a conscientious way. You could sue them. You could sue the employees of the big employer who helped set up the plan. You could sue a contractor or consultant that you relied on. All of these people would be open to lawsuits for punitive damages in State courts around the country.

That is a pretty obvious case. Let us take a different case, again with the beta blocker example. Let us suppose that a plan has a quality assurance plan. Many managed care plans do. So they go out and they try to make sure their physicians are up-to-date in all the latest kinds of medical developments. So they go out and give seminars on when you use beta blockers and when you use a cardiac cath or more kinds of aggressive treatment, and the physicians go to these seminars.

Then a patient is going to one of these physicians, and the physician recommends beta blockers in a particular case and you get a bad result or what somebody alleges is a bad result or a physical injury. Now you can sue the plan because they were not aggressive enough in recommending cardiac cath.

But let us suppose the physician recommends the cardiac cath. Now you could sue the plan because in the way it operated its quality assurance plan they were not aggressive enough in recommending beta blockers. Or if they did not have a quality insurance plan you could sue them for that. Or if they did not have enough seminars in their quality assurance plan, you could sue them for that. Or if they did not require that the physicians attend all the seminars, you could sue them for that. And what would constitute an adequately and properly run quality assurance plan would be determined in State courts in jurisdictions all around this country, even though many of these plans are national plans.

So what a plan that was hired by a big employer would have to do with regard to quality assurance plans would differ from one circuit court in one State to another circuit court in another State. And if they got it wrong, if a jury believed they got it wrong, they would be open to unlimited damages, including punitive damages, and you could sue the employer and the employer's employee as well, although I will get to that language in a minute.

Let me give one more example, and I could give hypotheticals with my lawyer's hat on all night long. Let us assume a situation where somebody is having some heart pain or chest pain. They belong to a managed care network. They try and make an appointment with the cardiologist. They do not get in for a week or so, and, as a result, their condition worsens.

Now they say well, you do not have enough cardiologists who are close enough to me so I could get an appoint-

ment. So, again, you sue the plan. You say you have to have more cardiologists than this within a certain number of miles from me, and all the other plan participants as well.

Again you have the same kind of lawsuit, and again you have the standards for what is quality care being determined for national plans in State courts after the fact in jury deliberations in circuit courts all around this country. If you get it wrong, why, you owe punitive damages.

By the way, you can, of course, sue the people who consulted with you in determining how much cardiologists you had to have and the employees you hired to determine how many cardiologists you had to have, and all resulting in billions of dollars being transferred out of the health care system, out of the treatment room, into the court room.

Moreover, Mr. Speaker, not only would the plan and the employer in these circumstances be subject to punitive damages, they would not be able to avail themselves of any malpractice limits that had been passed in State statutes, because these actions are not for malpractice, these are actions for negligence or whatever the State statute provided in the operation of the health care plan.

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So it would not sound, as we lawyers call it, it would not arise out of a malpractice action. Therefore, you would not be allowed the limits that you would have in a malpractice action.

Let us go to the liability of the employer under these circumstances. I want to say, the bill contains, in a different provision, and I did not have it all here, a shield for employers from lawsuits. So the bill does have a defense. It says you cannot sue employers, except in certain circumstances.

These are the circumstances under which you can sue the employer or other plan sponsor, and that, of course, would include labor unions, in the event of a labor-management plan. You can sue the employer or the labor union for the exercise of discretionary authority to make a decision on a claim for benefits; not deny a claim for benefits, but whenever the employer or the labor union makes a decision on a claim for benefits.

So let us go back to the first hypothetical and put a lawyer's hat back on again. The case was where the question was whether the cardiologist would recommend beta blockers or whether the cardiologist would recommend a cardiac cath or some more aggressive treatment.

If the employer exercises his discretionary authority to deny the care recommended by the cardiologist, he has obviously made a decision on claim for benefits on the exercise of his discretionary authority, and if injury results, the employer would be open to lawsuits.

Remember, this includes small employers, not just big employers. It does

include the big employers, the big national plans, whose employees by and large are satisfied with their health care.

Suppose the employer grants or sustains the benefits and a bad result occurs. Now you can sue the employer saying, you were negligent in the exercise of your discretionary authority in sustaining the benefits. You should have overruled them.

But let us say the employer says, I do not want to get in this kind of liability. I am not going to do anything. I am not going to be involved in this process.

In the first place, they could be liable under ERISA. Under ERISA, the basic network of laws under which all this operates, the plan sponsor is supposed to be a fiduciary. They are supposed to operate the trust for the benefit of the participants.

If you explicitly refuse to exercise your discretionary authority on behalf of the participants, you have violated ERISA. But if you say, I am not going to exercise my discretionary authority, I am going to let the plan do everything, Mr. Speaker, you have exercised your discretionary authority not to exercise your discretionary authority, and you could be sued for that.

If I was counsel for the employer, I would say that is the most dangerous thing of all, because when you get before a jury, and I am going to bring this home to real life and real lawsuits in just a minute, when you get before a jury, you are going to have to explain to the jury why you did not care enough to try and oversee in any way the operation of your health care plan when somebody was injured as a result of that.

That kind of lawsuit is the least in the liability that the employer faces. And remember, there are punitive damages for this. There is no shield in this bill for the employer against punitive damages under any circumstances. Remember, you could sue the employees of the employer or the labor union under these circumstances.

I think you might be able to defeat this defense in other ways. Again, I don't want to get too exotic here with my hypotheticals, but I think you could say if an employer hires a health care plan and does not engage in adequate due diligence, does not look into enough whether that health care plan was a good plan, maybe willfully neglects doing that, that is the exercise of the discretionary authority to hire a bad plan when you should have known it was a bad plan, and you should have known it would result in affecting decisions made on claims of benefits, and as a result, the entire shield is removed.

Those are the kinds of hard cases when there is a serious injury to somebody that makes bad law. Those will be pushed in every courtroom in the country.

Let me go over again, and I am going to wrap this up in a minute, Mr. Speaker, but let me go over again what we

are talking about here, and the dangers that we are talking about: again, open-ended liability for employers, labor unions, health care plans, their employees, contractors, associations, for any physical injury that arises or is connected in any way with the operation or administration of any health care plan.

This is going to result in billions of dollars being spent in litigation, in avoiding litigation, in settling litigation that is not going to go to health care. It is going to result in a diminution, a lessening, Mr. Speaker, of benefits for individuals who have insurance, and a vast increase in the number of people who do not.

The final points. Again, the Norwood-Dingell bill does not define "person." So again, anybody can be sued: the health care plan, the employer, any of their employees. Employers are going to have to have directors and officers liability insurance for their employees who run human resources operations. They are going to have to have insurance on their employees, in order to get health insurance for the employees.

Winning is not everything. This is very important to understand. If I am a lawyer and I am representing somebody who has been hurt, and I do not criticize lawyers in saying this, they have an absolute obligation to zealously represent their client in an attempt to recover whatever they can recover for them if they have been physically injured. You are going to sue everybody. You are going to name everybody, including the employer.

Now, this defense is what we lawyers call an affirmative defense. So you are going to be sued in State court, you are going to raise this affirmative defense in the answer. When you file your original papers, you going to say, no, I was not exercising my discretionary authority, so under Federal law you cannot sue me.

Okay, immediately what is called the interrogatories go out. Immediately they ask you for every document relating to how you developed your health care plan or how you were involved in this particular decision. After that they begin the depositions. They will depose whoever it was, anybody who was involved in any way or should have been involved with choosing the health care plan. Meanwhile, of course, the legal bills are adding up, because of course you are having your lawyers write memos to try and determine what exactly this means, because these terms in here are not defined, so thousands and thousands and thousands of dollars in legal fees are adding up.

Then after the interrogatories and after the depositions, you file what is called a motion for summary judgment. In other words, you say to the court, look, it is evident from the information we have gathered so far that you cannot sue me under this bill. Now you are up to \$40,000, \$50,000, spent in legal fees, even if there is not a basis for claiming that you exercised your

discretionary authority to make a decision on benefits.

How is anybody going to know, because this is entirely new law? We are making it up in this bill. Many of these terms are undefined. Then, if you lose at that point, and very often a judge will exercise his discretion not to grant a motion for summary judgment and let the case go to a jury, now you are before a jury, and a jury is making a judgment about whether you exercised discretionary authority. So this legal term here, this aspect of Federal law, is going to be defined by juries all over the country.

Mr. Speaker, I talked to some people who came into my office who owned restaurants. I am the chairman of the Committee on Small Business, so I talk a lot to small business people. Small business people by and large want good employees, so they want to shape compensation packages to get good employees. They are by and large very distressed that they usually cannot offer as good health care as the big employers can because they cannot fashion big pools.

I asked them what would happen, what they would do if they were faced with this kind of liability. These were restaurant owners. The restaurant business is a business where many people who work in that business do not have health insurance. Many restaurant owners do not offer health insurance. I asked them what they do. They said, we will drop the health insurance. We cannot open ourselves to this kind of liability. These are not wealthy people.

If we talk to people who run big companies, who want their health plans to be good so people are satisfied because they have to compete for good employees, what are they going to do when their costs start going up? I hope none of them drop their coverage. At least the cost of the coverage is going to have to go up. They are going to have to reduce the number of benefits. They are going to have to increase the number of employees. They are going to have to pass along costs to their employees, and they are going to have access to poorer quality health insurance.

That is unprecedented liability for employers. I just reviewed that. External review is useless. The Norwood-Dingell bill requires resort to external review in the event of a denial of a claim. Well, most of the actions I have just talked about do not involve denying a claim, so the external review that I talked about in the beginning that is the answer to the problem of accountability would not even be available. We cannot go to external review on the issue of whether a quality assurance plan was adequate or not.

Also, the bill permits people to avoid external review when there is injury suffered before the external review panel can meet. So if the heart condition gets worse in the week while you are waiting for external review, you can get around it and you can sue.

We ought not to be getting people out of external review. That is the right answer. We ought to be encouraging people to go into external review so that physicians are reviewing the decisions of physicians, not juries or courtrooms reviewing the decisions of physicians.

Finally, Mr. Speaker, the liability provisions in the Norwood-Dingell bill would apply to private sector employees, but would not apply to Federal employees. They would not apply to Congressmen. This is a liability provision which is supposedly good for people, but once again, Congress would exempt itself from the operation of this procedure.

Now, I have talked with some Members today. They indicated to me that, no, they thought well, maybe you could not sue if you were a Federal employee. Maybe today you could not sue the Federal Government, and right there you have a difference, because the Norwood-Dingell bill allows you to sue employers. Under current law, you cannot sue the Federal Government.

But they have told me, but you can at least sue the health care plan or the carrier with whom the Federal Government contracts. So they say, well, no, the Federal employees are excluded from the Norwood-Dingell bill. That is true, but that is because they can already sue their health plans or their health carriers.

Here is what title V, section 890 107(C) of the Federal regulations say with regard to actions by employees of the Federal Government.

It says, "A legal action to review final action by the OPM," the Office of Personnel Management, and you must go first to the Office of Personnel Management if you have a claim, "involving such denial of health benefits must be brought against OPM and not against the carrier or the carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute."

So under current law, which would not be changed by the Norwood-Dingell bill, Federal employees cannot sue their carriers, Federal employees cannot sue the Federal Government, but under this provision, employers, private employers, would be subject to actions.

Mr. Speaker, this does not have to be all or nothing at all. We do not have to go on with the current system, where people have rights, supposedly, under health care contracts, but no effective way of enforcing those rights. We can have accountability. We can do it through tightly-written, low-cost, easily accessible external review procedures where physicians are reviewing the decisions of other physicians. We can back that up with liability, in cases where the external review process is ignored or where it is fraudulent or where it is frustrated.

The least we need to do with the Norwood-Dingell bill is to make clear that

liability against the employer is strictly limited to cases where the employer directly participated in the denial of benefits. We need to make clear that punitive damages are strictly limited or not allowed. We need to require exhaustion of external review.

We need to be certain that where we allow quality of care actions, we make clear in the law what quality of care is, so that people know what the law is and can set up their health care plans accordingly, and we do not have that judgment being made in State courts around the country.

The reason, again, is because all of this makes a difference to real people who are really confronted with illness and the threat of illness. There are too many people in the United States today, Mr. Speaker, who do not have health insurance, and most of them do not have health insurance because it costs too much. Every time we increase the cost of health insurance, it means more and more people are not covered. Patient protections do not help you if you do not have insurance.

We have the chance in the next couple of days to pass good bills to increase accessibility, to increase the availability of private health insurance to people who do not have it, good private health insurance to these employees of small employers. We have the chance to hold HMOs accountable to get people in treatment rooms where they ought to be, not at home ill and untreated, and not in courtrooms afterwards, after they become seriously ill.

We can do these things. We have that opportunity. I want to close by saying that I welcome the fact that the bills have come this far. There are many competing factions in this House, and it is because of the passion and the energy of those factions that we have a bill and we have the opportunity to vote on it.

I have been working intensively on this for 2 years. I have wanted to see this day come. I am glad we have this opportunity. But let us not do something that will hurt the very people that we are trying to help. Let us not punish the employers and the small employers in this country and their employees by driving up the cost of health insurance to them in a way that is not necessary to ensure the kind of accountability that we all seek in the health care system.

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GENERAL LEAVE

Mr. GREEN of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the subject of the special order by the gentleman from Iowa (Mr. BOSWELL).

The SPEAKER pro tempore (Mr. WELDON of Florida). Is there objection to the request of the gentleman from Texas?

There was no objection.

TEXAS' EXPERIENCE WITH MANAGED CARE REFORM: A MODEL FOR THE NATION

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from Texas (Mr. GREEN) is recognized for 60 minutes as the designee of the minority leader.

Mr. Speaker, I want to thank you and also thank our minority leader for allowing me to have this second hour tonight and follow the gentleman from Missouri. Obviously, I agree with the gentleman from Missouri (Mr. TALENT) because Missouri has been the "Show Me State" all of my life, and for the next hour from Texas we are going to show him why he is wrong in his statements.

Mr. Speaker, I would like to first talk about that in the last 2 years in Texas we have had basically the same law that we are trying to pass here tomorrow and Thursday, and the examples offered by the gentleman from Missouri just do not hold water, at least they have not in the State of Texas.

First a little background. Before I was elected to Congress, I actually helped manage a small business in Houston, a printing business. One of my jobs in that business was to shop for our insurance and to make sure our 13 or so employees had adequate coverage, because our company was under a union contract and we could buy it from the union benefit plan or buy on our own if it was either equivalent or better, and so we did that.

And having experience of shopping for a number of years for insurance as both a manager and one who had to make sure we also paid the bills at the end of the week so we could afford it, I bring that kind of experience of a small business, even though I do not serve on the committee.

The other thing I would like to mention, the gentleman talked a great deal of time about threats of suits for employers, and it is not in the intention of myself or the sponsors of the Norwood-Dingell bill that employers will be responsible unless they make those medical decisions. I have offered in my own district and even here in Washington to the National Association of Manufacturers, give me the language and we will sponsor it as an amendment to make sure that employers are not held liable unless they are putting themselves in the place of a health care provider or health care decision-maker. That is saying to their employees, No you cannot do this or you cannot do that.

Again, having been a manager, I know that sometimes employers and businesses can afford a Cadillac plan that pays for a lot. Sometimes they can only afford a Chevy plan that does not pay as much. But just so they are getting what they are paying for, for

their employees; and that is what I think the managed care reform and HMO reform issue is about and it has been about for the last 2 years.

Let me follow up too, the gentleman had mentioned that this bill does not cover Federal employees. Well, right now as a Federal employee or as a State government employee, we have the right to sue our insurance company. We have the right under our plan. All we are trying to do with this bill is to provide to all the other Americans some of the same rights as Members of Congress have. And also it covers the Federal insurance plans, whether it be BlueCross or whatever other plans, because there are so many of them that the consumer would have the right to go to the courthouse ultimately.

So there was a lot of things the gentleman said during his time; and hopefully during the next hour we will hear a lot of folks who have real-life experiences from the State of Texas, because we have had a Patients' Bill of Rights under State law for over 2 years, and it only covers insurance policies that are licensed by the State of Texas.

That is why we have to pass something on the Federal level, because 60 percent of the insurance policies in the district I represent come under ERISA, come under Federal law. Even though the State of Texas 2 years ago passed these very same protections, we have to do it on the Federal level to cover the citizens of Texas who do not come under the State insurance policy.

In fact, this next hour hopefully we will have a lot of folks, and people who like to hear Texas accents will hear them for the next hour, because we will talk about the Texas experience with a little bit of help from some of our Texas colleagues and some from other parts of the country.

Mr. Speaker, let me address some of the issues. The insurance industry and managed care organizations and HMOs have been repeatedly trying to scare the American people saying the bill that we are going to vote on, the Norwood-Dingell bill, would dramatically raise premiums and force employers to drop health insurance. I even heard one of the special interest groups say that this number would be as high as 40 percent.

Mr. Speaker, once they have spread all of this inaccurate information, let me give the experience that not only we have in Texas but also from the Congressional Budget Office. The Congressional Budget Office is a non-partisan agency. They analyzed the Patients' Bill of Rights and said that the best they could determine, that the cost to the beneficiaries under the Patients' Bill of Rights may cost \$2 a month. That is less than the cost of a Happy Meal to provide fairness and protection and accountability.

But in the State of Texas, even if one does not agree with the Congressional Budget Office, and sometimes I disagree with their estimates, we need to look at real-life experience for the last