PERIODIC REPORT ON NATIONAL EMERGENCY WITH RESPECT TO SUDAN—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committee on International Relations and ordered to be printed:

To the Congress of the United States:

As required by section 401(c) of the National Emergencies Act, 50 U.S.C. 1641(c), and section 204(c) of the International Emergency Economic Powers Act (IEEPA), 50 U.S.C. 1703(c), I transmit herewith a 6-month periodic report on the national emergency with respect to Sudan that was declared in Executive Order 13067 of November 3, 1997.

GEORGE W. BUSH.

THE WHITE HOUSE, *May 2, 2001.*

SOCIAL SECURITY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan (Mr. SMITH) is recognized for 5 minutes.

Mr. SMITH of Michigan. Mr. Speaker, I am going to talk about Social Security, a little bit about the problems, a little bit about the commission that was appointed today by the President of the United States, George Bush, to try to come to a conclusion that is going to keep Social Security solvent.

We have been looking and acknowledging for almost 6 years now the serious problem of Social Security solvency. It has been a problem because when we developed Social Security in 1934, it was set up as a pay-as-you go program, where current workers pay in their Social Security tax and it is immediately sent out to current retirees.

What we have been experiencing over the last 65 years is a dwindling number in the birth rate and an increasing lifespan of seniors. So, for example, in 1942, we had almost 40 people working paying in their Social Security tax for every one retiree. Today, yes, Mr. Speaker, there are three people working paying a much higher Social Security tax to accommodate every one retiree.

The guess is that within 20 years, it is going to be two workers paying their tax for one retiree, so the challenge is increasing the return on that money that is being paid in by employees and employers in the United States.

Right now, the average employee is going to get a 1.7 percent return on the money they have paid in to Social Security in Social Security taxes. Today the President appointed a commission. It was my recommendation that we do not use a commission to further delay the implementation of a solution for this, because the fact is that the longer we put off this decision, the more drastic the changes are going to have to be.

There are only two ways to solve the Social Security dilemma: We either increase the revenues, or we decrease the benefits and the amount of money going out.

□ 1645

And what some of us have been suggesting for several years is that we increase revenue by getting a better real return on some of that money rather than simply lending it to the Government.

We have heard a lot of bragging that we are paying down the public debt. Actually, we are borrowing the money from Social Security and writing an IOU and then using that money to pay down the so-called debt held by the public, or I call it the Wall Street debt.

I urge the President to urge this commission to move quickly. I urge the commission to look at the legislation that many of us have been introducing over the last 6 or 7 years to make sure we keep Social Security solvent.

I think it is very important for the American people to know, Mr. Speaker, that we should not accept any recommendation from the White House that does not keep Social Security solvent for at least the next 75 years. It is too easy to say let us put Social Security first and then do nothing except add rhetoric and maybe pay down the debt a little bit. But what we have done with the so-called lockbox, with the so-called paying down the debt held by the public, does not help solve the long-term Social Security problem.

So I appreciate this time, Mr. Speaker; and I urge the commission to act as quickly as possible. I do see members of that commission that are going to be on the bottom end of the learning curve. That means that if they are going to understand the complexity and seriousness of the Social Security problem, that they need to do a lot of burning of the midnight oil.

PATIENT PROTECTION AND PRESCRIPTION DRUG COVERAGE LEGISLATION

The SPEAKER pro tempore (Mr. GRAVES). Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, just a heads up, I will probably only take about half of this time, so that if any Members on the other side are going to give a Special Order, they should realize that I will not take the full hour.

Mr. Speaker, I want to talk a little bit about two health care issues that are very important: patient protection legislation and prescription drug coverage. Just last night, Mr. Speaker, I was at an event here in Washington, and a gentleman who is a CEO of one of the world's largest corporations received an award. This gentleman had had, when he was a child, a bilateral cleft lip repaired, and he spoke beautifully. He has risen to the pinnacle of the business world. He had the advantage of having the appropriate care when he was a baby. And yet if we look at what has happened, my colleagues, around the country, with the advent of managed care, we will see cases like this.

Before coming to Congress, I was a plastic and reconstructive surgeon. I took care of lots of babies that were born with birth defects like this, a cleft lip and a cleft palate. And in the last several years, at least 50 percent of the surgeons who take care of children with birth defects like this have had operations on their patients denied because they were not ''medically necessary.'' Not medically necessary.

Let me give a few other examples. In 1996, Musette Batas was 6 months pregnant when she had an inflammatory bowel disease flare-up. Her insurance company authored a 1-day hospitalization. Her primary care physician asked for a longer stay, but her HMO concurrent review nurse looked at Mrs. Batas' chart and said it was not ''medically necessary.''

Now, the nurse never consulted with the physician; she never saw the patient. Musette Batas went to the emergency department 10 days later with fever and pain. A physician sought approval for exploratory surgery. Three days later, the doctor still had not heard from the HMO and her intestine burst. Four days after emergency surgery, in which part of her colon was removed, the HMO nurse told her physician she had to be discharged. The physician refused. The nurse reviewed her chart, she consulted Millimen and Robertson's care guidelines, and based on that, the nurse said the HMO would not pay for any more time in the hospital because it was not ''medically necessary.'' So she left the hospital because she could not afford to pay for it herself.

How about down in Texas in the last few years? There is a gentleman named Plocica. Mr. Plocica. He was suicidal. He was in the hospital. His psychiatrist said he needed to stay in the hospital. His HMO said no, we do not think he does. It is not medically necessary. So we are not going to pay for any more hospitalization. And when an HMO does not pay for a hospitalization, most people cannot stay in the hospital because they cannot afford the care.

They could not afford to pay for it out of pocket, so Mr. Plocica went home. His family reluctantly took him home, and that night he drank half a gallon of antifreeze and he committed suicide.

How about Nancy T. Vogel? She had a total abdominal hysterectomy to remove two tumors that weighed more than 3½ pounds. Her doctor said she needed at least 96 hours in the hospital to recover. As a physician, I would say that is the minimum. An HMO nurse looked at Millimen and Robertson's guidelines, guidelines that are used by HMOs, and determined that only 48 hours was medically necessary. So she left after 48 hours.

I would argue that those definitions of ''medical necessity'' are a medical judgment under those HMO contracts. I think a licensed physician should be the one making those medical judgments, not the HMO. And certainly not based on guidelines like Millimen and Robertson's. In fact, Millimen and Robertson's itself admits that its guidelines are not based on prevailing medical opinion but are ''goals'' that predict what should happen in the best cases with patients free of any complications.

How about this case? Another medical judgment case by an HMO. A little baby, James, who was about 6 months old when this picture was taken. One night he has a temperature of about 104, 105. He is really sick. It is 2 or 3 in the morning. His mother phones the 1–800–HMO number, explains that her baby is really sick and needs to go to the emergency room, and from some disembodied voice thousands of miles away she gets instructions: I want you to go to this particular hospital, and that is the only hospital I will authorize you to go to, because that is the only one we have a contract with. And the mother says, well, where is it? And the reviewer says, well, I do not know, find a map.

So they start looking for this hospital. It is 70 miles away, clear on the other side of Atlanta, Georgia. But mom and dad, they are not medical professionals, they do not know exactly how sick little James is. They do know that if they go to an unauthorized hospital they will be stuck with the bill, and they are not rich people.

So they bundle Jimmy up, they start on their trip, and halfway through the trip they pass three emergency rooms that they could have stopped at but for which they did not have an authorization. They were not told by the reviewer that their baby was really sick, take him to the nearest emergency room. Oh no, we will only authorize care at this very distant hospital. And before they get to the hospital, little James has a cardiac arrest.

So imagine this. You are dad, driving like crazy, and mom trying to keep this little baby alive, after the HMO makes a medical judgment over a telephone never having seen the baby. Well, they come screeching into the emergency room. Mom leaps out of the car screaming, ''Save my baby. Save my baby.'' Nurses come running out, and they manage to get an IV started. They manage to get the baby's heart going, and they save his life. The wonders of modern medicine. But they were not able to save all of Jimmy, because Jimmy ended up with gangrene in both hands and both feet. Because of that HMO's medical judgment, both of his hands and both of his feet had to be amputated.

My colleagues will be happy to know that under a Federal law that was passed by Congress 25 years ago, that HMO is liable for nothing for that negligent medical decision other than the cost of care needed, i.e., his amputations. Is that justice?

We had testimony 4 years ago in front of my committee from an HMO medical reviewer who testified that she had made decisions that had cost people their lives. She had denied them proper care, and she could hide behind what she called the smart bomb of HMO cost containment: denials on medical necessity.

In fact, under contracts that HMOs can write, they can define medical necessity in any way they want to under the Federal law ERISA. They can write a contract with an employer that says we define medical necessity as the cheapest, least expensive care. A person who does not have enough blood supply going to his legs, where a physician could save the legs by vascular reconstruction, that HMO could justify an amputation. Because, after all, under their own definition, that is the cheapest, least expensive care.

We have to do something to fix this. This is a travesty. We have been having this debate on patient protection for 5 years now, and yet the forces of the HMO industry have spent hundreds of millions of dollars to try to defeat us. Eighty-five percent of the people in this country want to have Congress fix that Federal law. They think Congress should do something to prevent a travesty like this from happening.

□ 1700

Our bill would do that. The Ganske-Dingell bill in the House, the McCain-Edwards bill in the Senate, we set up a system to prevent this type of thing from happening, Mr. Plocica from being sent home prematurely from the hospital and then committing suicide.

We set up a review process because if there is a disparity based on standard of care, ultimately you can go to an independent review panel. Even on an expedited basis, you can get an independent panel to make a medical judgment, a panel that does not have a conflict of interest, that is not paid for by the HMO, so that you would know that they would be independent and be giving you the truthful answer.

We believe our bill would prevent the types of lawsuits that resulted from the care that Nancy Vogel received. But more importantly, we think that if our bill were law, we could help prevent a little boy from losing both hands and both feet, Mr. Plocica from committing suicide, Nancy Vogel from being sent home prematurely after having 3.5 pounds of tumor removed from her belly.

I ask my colleagues to talk to their constituents back home about this issue. I guarantee that a very large percentage of them will not have been treated fairly by their employer's health plan, or they know somebody at work who has not been treated fairly, or they have a family member who has not been treated fairly. Let us pray to God that they have not had somebody who has lost their life, because that has happened also, as has been outlined in cover stories in Time magazine.

It is time for this Congress to do something on the Patients' Bill of Rights, something real, not an HMO protection bill, but something that helps people.

I urge this Congress to move forward expeditiously. I urge the Senate to bring this bill up as soon as possible, and I think that we will do that on the House side also. I ask my colleagues not to listen to the HMOs.

Whose side are you going to be on? Are you going to be on the side of your constituents and your patients, or are you going to be on the side of the HMOs? Can you justify a Federal law that gives legal immunity to health plans that are making life-and-death decisions millions of times a day, when just a year ago we held hearings in this House on Bridgestone and Firestone, on tires that blew up. Is there any other industry in this country that has legal immunity other than foreign diplomats?

It was a perversion of the law 25 years ago, that was passed to be a consumer protection law for pensions, that became an avenue for HMOs to avoid their responsibility, a way for them to cut corners regardless of whether it hurt people. This Congress has a moral obligation to come back and fix that Federal law. We should do it soon.

Now let me talk a little bit about another health care issue that is really important. That is the issue of the high cost of prescription drugs.

Mr. Speaker, this is a photo of Bill Newton. He is 74 years old from Altoona, Iowa, my district. His savings vanished when his late wife, Juanita, whose picture he is holding, needed prescription drugs which cost as much as $600 per month. He said, ''She had to have them. There was no choice. It is a very serious situation and it is not getting any better because drugs keep going up and up.''

Mr. Speaker, I have constituents that write me letters, some of them go down to Texas for vacation and they go across the border to Mexico and they find that their prescription drug costs are half of what they are in the United States. Look at the difference in drug costs between the United States and Europe.

Premarin: U.S. price, $14.98; European price, $4.25. Coumadin: 25 pills, 10 milligrams, $30 in the United States, $2.85 in Europe.

How about Claritin, for 20 10-milligram pills, it costs $44 in the United States and it costs $8.75 in Europe.

We need to do something about this. We need to do something about the high cost of prescription drugs, not just for senior citizens, but for everyone. Because, Mr. Speaker, the main reason why health insurance premiums have gone up so fast in the last couple of years has been to cover the 20–25 percent annual increase in the cost of prescription drugs.

Now, last year, we had a Republican bill and a Democratic bill. Both of

them were voluntary. Both of them were set up essentially so that a person had to have about $1,000 out-of-pocket expense before they would get a benefit for the increased premiums that they would pay. And both of those bills' premiums were premised on the fact that 85 percent of seniors would sign up for the program.

Mr. Speaker, look at this data from 1999: 14 percent of senior citizens had no drug expenditures a couple of years ago; 36 percent had less than $500; another 19 percent had less than $1,000. That meant that 50 percent of the Medicare population had drug expenses that were less than what the cost of their premiums would have been under either the Republican or the Democratic plan last year. Under a voluntary plan, that becomes very questionable whether people will sign up for a benefit if it is going to cost them more than the benefit is worth.

Last year, when I talked about this on the floor, we had some predictions in terms of what those costs would be.

I remember back in 1988, I was not in Congress then, but I remember when Congress passed a catastrophic bill with a prescription drug benefit, passed it one year and repealed it the next because the senior citizens did not like the premium increases. I remember within 6 months the Congressional Budget Office had doubled their estimates for what the cost would be.

I think it is informative to look at what the estimates today are for what last year's House Republican and the Democratic bills were. Last year, the House Republicans estimated that the bill would cost $150 billion. The new estimate in about a 6-month period of time is now, and if that bill were law, it would cost $320 billion. So in a 6-month period, the estimate for the cost of the Republican bill, that passed this House, more than doubled.

How about the Democratic bill from last year, the Daschle bill? It was estimated last year that it would cost $300 billion. This year the estimate, if that were law, it would cost $550–$600 billion.

Now, here are some figures that are mind-boggling. The CBO, the Congressional Budget Office, estimate for how much prescription drugs would cost senior citizens for the years 2002 to 2011 is $1.456 trillion. Now, last year, we thought that the Federal Government would cover about, roughly speaking, 35 percent of that cost. That means that the estimate from last year, which was $150 billion, would be today $510 billion.

Last year, we estimated the cost at providing full coverage for low-income seniors to be something in the range of $80 billion. Well, if we look at the new figures, if we are talking about covering prescription drugs for people who are below the poverty line, for 100 percent of people below the poverty line, we are now looking at an estimate of $255 billion. If we move it up to 135 percent, it would be $425 billion. If we move it up to 175 percent, it would be $600 billion.

Some of those costs are already being covered by Medicaid, so probably $120 billion could be deducted from this, which means that if we are talking about covering low-income seniors, let us say from 135 percent of poverty to 175 percent of poverty, we are probably looking at needing at least $300 billion just to do that.

Now, Mr. Speaker, I want my colleagues to listen to this. Under the current budget resolution which will probably come to the House in the next few days, we have only budgeted $300 billion for a prescription drug benefit. That means that we would essentially cover low-income seniors and no one else. But I would bet that 6 months from now those estimates will be readjusted higher than they are now. That is just typically the way that it has been when we have tried to estimate prescription drug costs.

That is why I have a bill before Congress which I encourage my colleagues to sign onto that I think is realistic. It addresses the difference in cost between prescription drugs made in the U.S., but sold overseas, and helps fix the reimportation loopholes. It does that.

But for Medicare, it will help the low-income senior citizen who is not so poor that he or she is already on Medicaid, getting a drug benefit from Medicaid, but allow senior citizens up to 135 percent of poverty and then phased out to 175 percent of poverty to utilize the State Medicaid drug programs and pay for it from the Federal side. We are not requiring a match from the State legislatures or the State governors because a lot of them are finding that they are under budgetary constraints.

No cost share; we provide for this on the Federal side, but we utilize the State programs that are already in place. We do not have to duplicate the wheel. Those State programs have already negotiated discounts with the pharmaceuticals, and that benefit, I think, would fit within what we are talking about for a budget. And it is an important first step on this.

Mr. Speaker, it would help the senior citizen, the elderly widow who today is trying to pay her energy bills, her food, her housing, and her prescription drugs off of a Social Security check. She needs that help; and we can do that.

But I want to tell my colleagues what the really scary statistic is. That is that these 10-year projections for what the costs are going to be for prescription drug coverage, whether we are talking at the 35 percent level or a 50 percent level, they all go up, and this is really important, I hope my colleagues are listening to this, these estimates are all from 2002 to 2011.

□ 1715

I want to ask my colleagues something. What happens in the year 2012? I will tell my colleagues what happens. The baby boomers start to retire in 2012. That age wave, my demographic group, the baby boomers, start to retire. We will double the number of Medicare senior citizens in about 20 years, but we start that in the year 2012. If my colleagues think that this prescription drug program is expensive now, wait till 2012 when the baby boomers start to retire and we will not just see $1.4 or $1.5 trillion, we will see multiple trillions of dollars. And then we are going to have to ask ourselves, how do we find those funds? How do we keep the other aspects of Medicare such as hospital care going?

We cannot just think, Mr. Speaker, about a 10-year window. We have to take into account that in 2012, 1 year past this 10-year window, the baby boomers start to retire; and we are going to see astronomical increases in Medicare costs. I beg my colleagues, when we are looking at doing a benefit on prescription drugs, and next year when the elections start to roll closer and the pressures get heavy to get something done on prescription drugs, which I think we ought to, and I think we ought to help senior citizens who need it the most, let us look at a way to do this program that helps those that need it the most and then see where we are going to be past that 10-year window. Maybe Medicare reform will help on that. But I think we ought to see the proof in the pudding before we start committing ourselves, not just to $1.5 trillion but to multiple, multiple trillions of dollars on a prescription drug benefit.

On that cheery news, Mr. Speaker, I remain eternally optimistic that we are going to muddle our way through, that we will pass a real patients' bill of rights through a lot of hard work and contention, and I am sincerely hopeful that we will be able to look at a prescription drug benefit and do the right thing for this.

PRESCRIPTION DRUG COVERAGE FOR SENIORS

The SPEAKER pro tempore (Mrs. CAPITO). Under the Speaker's announced policy of January 3, 2001, the gentleman from Texas (Mr. TURNER) is recognized for 60 minutes as the designee of the minority leader.

Mr. TURNER. Madam Speaker, I would like to talk about a subject this evening that has been ignored, I think, for the entire Congress that we have been in since the first of the year, an issue that many of us feel very strongly about, an issue that many of us campaigned on on both sides of the aisle, an issue that I think must be dealt with if we are going to have a budget that is honest and realistic, and that is dealing honestly with the problem of providing prescription drug coverage for our senior citizens.

Tomorrow, this House will vote on a budget that emerges from a conference committee. The details of that budget at this hour, at this late hour, are still very murky, but one thing is clear: a