system which the Sikhs of Khalistan, the Muslims of Kashmir, the Christians of Nagaland, and so many others are trying to escape. The corruption and the repression are tied together. The State Department reported that between 1991 and 1993, the regime paid over 41,000 cash bounties to police officers for killing Sikhs. Justice Ajit Singh Bains reports that more than 50,000 Sikhs disappeared or were murdered from 1992 through 1995. These events occurred on Mr. Rao's watch.

I am pleased that P.V. Narasimha Rao is finally facing the consequences of his corruption, but it is time that he also faced the consequences of his brutal terror campaign against the Sikh nation. As Home Minister in 1984, Mr. Rao was the person who organized the Delhi massacres that killed 20,000 Sikhs. When will he be indicted for these crimes?

In addition to its repression and corruption, India is a country that never misses an opportunity to take a swipe at the United States. Although it is one of the largest recipients of United States aid, India has a virulently anti-American voting record at the United Nations, and it is the country that single-handedly blocked the Comprehensive Test Ban Treaty [CTBT]. It is in America's interest to support the freedom movements in the subcontinent.

Unfortunately, the Sikhs and others continue to live under the brutal rule of a tyrannical regime. Recent events like the detention of American citizen Balbir Singh Dhillon and the savage beating of London-based Khalistani leader Jagjit Singh Chohan show that nothing has changed from Mr. Rao's brutal and corrupt rule. It is time for the United States to take a firm stand against these atrocities. We must institute an embargo against Indian companies and products. We must end United States aid to India. Finally, we must speak out for the freedom of Khalistan, Kashmir, Nagaland, and all the others seeking their freedom from India. Tyrants must know that America is on the side of freedom.

Mr. Speaker, I insert into the RECORD the September 22, 1996, Washington Post account of the Rao resignation.

INDIAN EX-PREMIER QUITS CONGRESS PARTY

NEW DELHI—Former Indian prime minister P.V. Narasimha Rao quit yesterday as head of the Congress party after a court upheld a summons ordering him to appear in a criminal case.

Although his party suffered a defeat in general elections earlier this year, Rao has retained a say in the nation's politics by offering his party's crucial support to the center-left United Front coalition government.

Rao, 75, said in a statement read at a news conference here by Congress general secretary Devendra Dwivedi that he was not guilty.

Earlier yesterday, a Delhi judge upheld the summons ordering Rao to appear in court September 30. Formal charges would be framed on the same day.

An Indian expatriate businessman, Lakhubhai Pathak, alleges Rao and a Hindu guru conspired conspired to cheat him of $100,000 in 1983.

THE MANAGED CARE CONSUMER PROTECTION ACT OF 1996

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 26, 1996

Mr. STARK. Mr. Speaker, I am pleased to introduce the Managed Care Consumer Protection Act of 1996, a bill that will provide critically needed consumer protections to millions of Americans in managed care health plans.

Health care consumers who entrust their lives to managed care plans have consistently found that many plans are more interested in profit than in providing appropriate care. My constituent mail has been full of horror stories explaining the abuses that occur at the hands of HMO's and other forms of managed care.

For example, David Ching of Fremont, CA had a positive experience in a Kaiser Permanente plan and then joined an employer sponsored HMO expecting similar service. He soon learned that some plans would rather let patients die than authorize appropriate treatment. His wife developed colon cancer, but went undiagnosed for 3 months after the first symptoms. Her physician refused to make the appropriate specialist referral because of financial incentives and could not discuss proper treatment because of the health plan's policy. Mrs. Ching is now dead.

In a similar case, Jennifer Pruitt of Oakland wrote to me about her father who also had cancer. He went to his gatekeeper primary care physician numerous times with pain in his jaw. The doctor, who later admitted that she had never treated a cancer patient, refused to refer Mr. Pruitt to a specialist. Eventually, after months of pain, a dentist sent Mr. Pruitt to a specialist outside of the HMO network. The cancer was finally diagnosed, but it had spread too rapidly during the months that the health plan delayed. Mr. Pruitt died from a cancer that is very treatable if detected early.

These tragedies and others like them might have been avoided if the patients had known about the financial incentives not to treat, or if the physicians had not been gagged from discussing treatment options, or if there had been legislation forcing health plans to provide timely grievance procedures and timely access to care. It's too late for these victims, but it is not too late to provide these protections for the millions of people in managed care today.

A few years ago, Congress recognized a crisis in the health care industry. Expenditures were soaring and overutilization was the rule. At that time, I chose to address this problem with laws that prohibited physicians from making unnecessary referrals to health organizations or services that they owned.

Others responded by pushing Americans into new managed care plans that switched the financial incentives from a system that overserves to a system that underserves. They got what they asked for. The current system rewards the most irresponsible plans with huge profits, outrageous executive salaries, and a license to escape accountability. Unfortunately, patients are dying unnecessarily in the wake of this health care delivery revolution. It must stop.

Several States have already addressed the managed care crisis. In 1996, more than 1,000 pieces of managed care legislation flooded State legislatures. As a result, HMO regulations were passed in 33 States addressing issues like coverage of emergency services, utilization review, post-delivery care and information disclosure. Unfortunately, many States did not pass these needed safeguards resulting in a piecemeal web of protections that lacks continuity. The states have spoken; now it's time for Federal legislation to finish the job and provide consumer protections to all Americans.

The bill I offer today is a revision of an earlier bill, H.R. 1707, the Medicare Consumer Protection Act of 1995. This legislation includes a comprehensive set of protections that will force managed care plans to be accountable to all of their patients and to provide the standard of care they deserve.

In the U.S. Congress, we have the power to put an end to abuse in managed care and guarantee that Americans who choose managed care get the care for which they pay. It is irresponsible to do anything less.

Following is a summary of the consumer protections provided for in this bill.

MANAGED CARE CONSUMER PROTECTION ACT OF 1996

SUMMARY

I. MANAGED CARE ENROLLEE PROTECTIONS

A. UTILIZATION REVIEW

1. Any utilization review program that attempts to regulate coverage or payment for services must first be accredited by the Secretary of Health and Human Services or an independent, non-profit accreditation entity;

2. Plans would be required to provide enrollees and physicians with a written description of utilization review policies, clinical review criteria, information sources, and the process used to review medical services under the program;

3. Organizations must periodically review utilization review policies to guarantees consistency and compliance with current medical standards and protocols;

4. Individuals performing utilization review could not receive financial compensation based upon the number of certification denials made;

5. Negative determinations about the medical necessity or appropriateness of services or the site of services would be required to be made by clinically-qualified personnel of the same branch of medicine or specialty as the recommending physician;

B. ASSURANCE OF ACCESS

1. Plans must have a sufficient number, distribution and variety of qualified health care providers to ensure that all enrollees may receive all covered services, including specialty services, on a timely basis (even in rural areas);

2. Patients with chronic health conditions must be provided with a continuity of care and access to appropriate specialists;

3. Plans would be prohibited from requiring enrollees to obtain a physician referral for obstetric and gynecological services.

4. Plans would demonstrate that enrollees with chronic diseases or who otherwise require specialized services would have access to designated Centers of Excellence;

C. ACCESS TO EMERGENCY CARE SERVICES

1. Plans would be required to cover emergency services provided by designated trauma centers;

2. Plans could not require pre-authorization for emergency medical care;

3. A definition of emergency medical condition based upon a prudent layperson definition would be established to protect enrollees from retrospective denials of legitimate claims for payment for out-or-plan services;

4. Plans could not deny any claim for an enrollee using the ''911'' system to summon emergency care.

D. DUE PROCESS PROTECTIONS FOR PROVIDERS

1. Descriptive information regarding the plan standards for contracting with participating providers would be required to be disclosed;

2. Notification of a participating provider of a decision to terminate or not to renew a contract would be required to include reasons for termination or non-renewal. Such notification would be required not later than 45 days before the decision would take effect, unless the failure to terminate the contract would adversely affect the health or safety of a patient;

3. Plans would have to provide a mechanism for appeals to review termination or non-renewal decisions.

E. GRIEVANCE PROCEDURES AND DEADLINES FOR RESPONDING TO REQUESTS FOR COVERAGE OF SERVICES

1. Plans would have to establish written procedures for responding to complaints and grievances in a timely manner;

2. Patients will have a right to a review by a grievance panel and a second review by an independent panel in cases where the plan decision negatively impacts their health services;

3. Plans must have expedited processes for review in emergency cases.

F. NON-DISCRIMINATION AND SERVICE AREA REQUIREMENTS

1. In general, the service area of a plan serving an urban area would be an entire Metropolitan Statistical Area (MSA). This requirement could be waived only if the plans' proposed service area boundaries do not result in favorable risk selection.

2. The Secretary could require some plans to contract with Federally-qualified health centers (FQHCs), rural health clinics, migrant health centers, or other essential community providers located in the service area if the Secretary determined that such contracts are needed in order to provide reasonable access to enrollees throughout the service area.

3. Plans could not discriminate in any activity (including enrollment) against an individual on the basis of race, national origin, gender, language, socioeconomic status, age, disability, health status, or anticipated need for health services.

G. DISCLOSURE OF PLAN INFORMATION

1. Plans would provide to both prospective and current enrollees information concerning:

Credentials of health service providers

Coverage provisions and benefits including premiums, deductibles, and copayments

Loss ratios explaining the percentage of premiums spent on health services

Prior authorization requirements and other service review procedures

Covered individual satisfaction statistics

Advance directives and organ donation information

Descriptions of financial arrangements and contractual provisions with hospitals, utilization review organizations, physicians, or any other health care service providers

Quality indicators including immunization rates and health outcomes statistics adjusted for case mix

An explanation of the appeals process

Salaries and other compensation of key executives in the organization

Physician ownership and investment structure of the plan

A description of lawsuits filed against the organization

2. Information would be disclosed in a standardized format specified by the Secretary so that enrollees could compare the attributes of all plans within a coverage area.

H. PROTECTION OF PHYSICIAN—PATIENT COMMUNICATIONS

1. Plans could not use any contractual agreements, written statements, or oral communication to prohibit, restrict or interfere with any medical communication between physicians, patients, plans or state or federal authorities.

I. PATIENT ACCESS TO CLINICAL STUDIES

1. Plans may not deny or limit coverage of services furnished to an enrollee because the enrollee is participating in an approved clinical study if the services would otherwise have been covered outside of the study.

J. MINIMUM CHILDBIRTH BENEFITS

1. Insurers or plans that cover childbirth benefits must provide for a minimum inpatient stay of 48 hours following vaginal delivery and 96 hours following a cesarean section.

2. The mother and child could be discharged earlier than the proposed limits if the attending provider, in consultation with the mother, orders the discharge and arrangements are made for follow-up post delivery care.

II. AMENDMENTS TO THE MEDICARE PROGRAM, MEDICARE SELECT AND MEDICARE SUPPLEMENTAL INSURANCE REGULATIONS.

A. ORIENTATION AND MEDICAL PROFILE REQUIREMENTS

1. When a Medicare beneficiary enrolls in a Medicare HMO, the HMO must provide an orientation to their managed care system before Medicare payment to the HMO may begin;

2. Medicare HMOs must perform an introductory medical profile as defined by the Secretary on every new enrollee before payment to the HMO may begin.

B. REQUIREMENTS FOR MEDICARE SUPPLEMENTAL POLICIES (MEDIGAP)

1. All MediGap policies would be required to be community rated;

2. MediGap plans would be required to participate in coordinated open enrollment;

3. The loss ratio requirement for all plans would be increased to 85 percent.

C. STANDARDS FOR MEDICARE SELECT POLICIES

1. Secretary would establish standards for Medicare Select in regulations. To the extent practical, the standards would be the same as the standards developed by the NAIC for Medicare Select Plans. Any additional standards would be developed in consultation with the NAIC.

2. Medicare Select Plans would generally be required to meet the same requirements in effect for Medicare risk contractors under section 1876.

Community Rating

Prior approval of marketing materials

Intermediate sanctions and civil money penalties

3. If the Secretary has determined that a State has an effective program to enforce the standards for Medicare Select plans established by the Secretary, the State would certify Medicare Select plans.

4. Fee-for-service Medicare Select plans would offer either the MediGap ''E'' plan with payment for extra billing added or the MediGap ''J'' plan.

5. If an HMO or competitive medical plan (CMP) as defined under section 1876 offers Medicare Select, then the benefits would be required to be offered under the same rules as set forth in the MediGap provisions above. Such plans would therefore have different benefits than traditional MediGap plans.

D. ARRANGEMENTS WITH OUT OF AREA DIALYSIS SERVICES.

E. COORDINATED OPEN ENROLLMENT

1. The Secretary would conduct an annual open enrollment period during which Medicare beneficiaries could enroll in any MediGap plan, Medicare Select, or an HMO contracting with Medicare. Each plan would be required to participate.

III. AMENDMENTS TO THE MEDICAID PROGRAM

A. ORIENTATION AND IMMUNIZATION REQUIREMENTS

1. When a Medicaid beneficiary enrolls in a Medicaid HMO, the HMO must provide an orientation to their managed care system before Medicaid payment to the HMO may begin;

2. Medicaid HMOs must perform an introductory medical profile as defined by the Secretary on every new enrollee before payment to the HMO may begin.

3. When children under the age of 18 are enrolled in a Medicaid HMO, the immunization status of the child must be determined and the proper immunization schedule begun before payment to the HMO is made.

TRIBUTE TO FATHER JAMES SAUVE

HON. BENJAMIN A. GILMAN

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 26, 1996

Mr. GILMAN. Mr. Speaker, I am pleased to join with my colleagues in paying tribute to an outstanding American who passed away earlier this week.

Father James Sauve, the executive director of the Association of Jesuit Colleges and Universities, was a highly respected educator. As the director of the International Center for Jesuit Education in Rome, as the official representative of the 28 Jesuit colleges and universities, and as a highly respected pastor, Father Sauve threw himself into his work with gusto and zeal, and in so doing earned the respect of all of us.

Father Sauve was a graduate of Spring Hill College in Alabama, and received his Ph.D. from Johns Hopkins University. He was proficient in six languages, and traveled extensively throughout the world.

Father Sauve's sudden passing was a loss not only to the Jesuit world, but to all of us who appreciate learning and understanding of all cultures.

We join in the sorrow of Father Sauve's surviving family, which consists of his father, Willard, and his brother, Dudley, and his family. We also join all of Father Sauve's many students whose sense of loss must be immense.

HUMAN RIGHTS ABUSES IN EAST TIMOR

HON. TONY P. HALL

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 26, 1996

Mr. HALL of Ohio. Mr. Speaker, for many years I have been deeply concerned over the tragedy in the former Portuguese colony of East Timor. I have had the privilege of meeting the Roman Catholic Bishop of East Timor, Carlos Ximenes Belo, on several occasions.