

Have they read about that? Or did they read about the Baltimore Orioles or the Harlem Globetrotters playing with Cuba's national teams? Is that what we read about? That is the only thing that the press covers with regard to Cuba. How cute, the Baltimore Orioles or the Harlem Globetrotters playing Castro's designated national team. That is the only coverage, in essence, with very rare exceptions.

It is time to help the internal opposition, Madam Speaker. A number of us are filing, we prepared legislation that basically tells the President of the United States, we in the Congress, we passed a law 3 years ago saying he is authorized to help the internal opposition in Cuba, to find ways to do it like we did in Poland, and he has not done it, and it is time that we do it and we are filing legislation to do so.

It is time that the world learn the names of the Vaclav Havels and the Lech Walesas of Cuba. It is time that the world be able to put faces to those names and names to those faces. It is time to help the internal opposition.

We will be filing this legislation. We need the support of our colleagues. It does not deal with the embargo. They can be pro-trade, anti-trade, or in the middle. They can stand for the Cuban people's right to be free by supporting this legislation that calls on the President to devise a plan, like was done by President Reagan in Poland, to help the internal opposition.

And we talk to those now members of parliament in Poland or the President in the Czech Republic and they will tell us what it meant when we had a President in the United States who stood with them and found ways to help them when they were dissidents and when they were being persecuted by their communist totalitarian regimes.

That is what we need to do in the case of Cuba. Cuba will be free. The Congress has always been on the side of the Cuban people. What we need is the President to speak up on this issue on these people 90 miles away, our closest friends, our closest neighbors, to stand on their side and against the repressor.

We need the administration to be heard. The Congress is heard, will continue to be heard, has been heard. And we are going to file our legislation, and we need the support of our colleagues. I know we have it, because always the Congress of the United States have stood with the Cuban people. And the Cuban people, when they are free, they will remember this Congress for having stood always for their right to be free, for self-determination, for freedom for dignity, for free elections and against the horrors of their 40-year totalitarian nightmare.

PATIENT PROTECTION LEGISLATION

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

Mr. GANSKE. Madam Speaker, it is *deja vu* all over again. Delay patient protection, keep it from the floor, try to push it back in the legislative year so that time will run out, or load up a clean patient bill of protection with a lot of extraneous, untested ideas and then let it sink of its weight.

Madam Speaker, I would think that we would learn in this House that the American public is demanding that Congress address this problem. I recently learned, Madam Speaker, that the leadership of the House is not thinking about bringing patient protection legislation to the floor until October at the earliest. And I also learned, Madam Speaker, that the chairman of jurisdiction is considering adding a number of untested ideas to a clean bill of patient rights, things like health marts or association health plans, ideas which have not been tested, which could actually be harmful.

Why is this a disaster, Madam Speaker? Well, consider the case of little James Adams, age 6 months. At 3:30 in the morning his mother Lamona found him hot, panting, sweaty, moaning. His temperature was 104. Lamona phoned her HMO and was told to take James to Scottish Rite Medical Center. "That is the only hospital I can send you to," the reviewer added.

"Well, how do I get there?" Lamona said.

"I do not know. I am not good at directions."

So at about 3:30 in the morning Lamona and her husband wrap up little Jimmy, little sick Jimmy. It was raining out, terrible night. They get in their car. They live way on the east side of Atlanta, Georgia, about 20 miles.

About 20 miles into their ride they pass Emory Hospital's emergency room with a renowned pediatric medical center. Nearby are two more of Atlanta's leading hospitals, Georgia Baptist and Grady Memorial. But they did not have permission to stop, and they knew that if they did the HMO would stick them with the bill. So not being medical professionals, they thought, "We think we can get there in time."

They had 22 more miles to travel before they got to Scottish Rite. While searching for the hospital, James's heart stopped. Madam Speaker, think of what it was like for Mr. and Mrs. Adams, driving frantically in the early morning hours, trying to resuscitate and keep little Jimmy alive while they push on to the emergency room.

Well, they got him to Scottish Rite eventually but it looked like he would die. But he was a tough little guy, and despite his cardiac arrest due to delay in treatment by his HMO, he survived. However, he ended up with gangrene of both of his hands and both of his feet. The doctors had to amputate both of little Jimmy's hands and both of his feet.

All this is documented in the book "Health Against Wealth," and the details of baby James' HMO's methods

emerged, and a judge who looked at this said the margins of safety of that HMO were razor thin. Madam Speaker, I would say about as razor thin as the scalpel that had to amputate little baby James' hands and feet.

Think of the dilemma this places on a mother struggling to make ends meet. In Lamona's situation, under last year's Republican task force bill, if she rushes her child to the nearest emergency room she could be at risk for a charge that is on average 50 percent more than what the plan would pay for in network care. Or she could hope that her child's condition will not worsen as they drive past other hospitals to finally make it to the ER that is affiliated with their plan. And woe to any family's fragile financial condition if this emergency occurs while they are visiting friends or family out-of-State.

Madam Speaker, cases like this are not isolated examples. They are not mere anecdotes. Madam Speaker, tell to little James today or to his mother Lamona, who I spoke to about a month ago, that James is just an anecdote. Those anecdotes, if we prick their finger, if they have a finger, they bleed.

Little James, with his bilateral leg amputations and his bilateral hand amputations, today with his arm stumps can pull on his leg prosthesis, but his mom and dad have to help him get on his bilateral hooks. Little James will never be able to play basketball or sports. Little James, some day when he marries the woman that he loves, will never be able to caress her cheek with his hand.

Madam Speaker, this is the type of disaster that the type of delay that we are seeing in this House and in this Congress in addressing this problem makes this a tragedy. Well, Madam Speaker, these cases have earned the HMO industry a reputation with the public that is so bad that only tobacco companies are held in better esteem.

Let me cite a few statistics. A national survey shows that far more Americans have a negative view of managed care than positive. By more than two to one, Americans support more government regulation of HMOs. The survey shows that only 44 percent of Americans think managed care is a good thing.

Do my colleagues need proof? Just remember the way the audience clapped and cheered during the movie "As Good As It Gets" when Academy Award winner Helen Hunt expressed an expletive, which I cannot repeat on the floor of Congress, about the lack of care her asthmatic son got from their HMO.

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No doubt the audience's reaction was fueled by dozens of articles and news stories highly critical of managed care. These are real-life experiences.

In September of 1997, the Des Moines Register ran an op-ed piece entitled "The Chilly Bedside Manners of HMOs" by Robert Reno, a Newsweek writer.

Citing a study on the end of life care he wrote, "This would seem to prove the popular suspicion that the HMO operators are heartless swine."

The New York Post ran a week-long series on managed care. The headlines included, "HMOs Cruel Rules Leave Her Dying for the Doc She Needs."

Another headline blared out, "Ex-New Yorker Is Told, Get Castrated So We Can Save Dollars."

Or maybe you are interested in this headline: "What His Parents Didn't Know About HMOs May Have Killed This Baby."

Or how about the 29-year-old cancer patient whose HMO would not pay for his treatments? Instead, the HMO case manager told him to hold a fund-raiser. A fund-raiser? Madam Speaker, I certainly hope that campaign finance reform will not stymie this man's effort to get his cancer treatment.

To counteract this, even some health plans have taken to bashing their colleagues. Here in Washington, one HMO's ads declared, "We don't put unreasonable restrictions on our doctors. We don't tell them that they can't send you to a specialist."

In Chicago, Blue Cross ads proclaimed, "We want to be your health plan, not your doctor."

In Baltimore, an ad for Preferred Health Network assured customers, "At your average health plans, cost controls are regulated by administrators. At PHN, doctors are responsible for controlling costs."

Madam Speaker, advertisements like these demonstrate that even the HMOs know that there are more than a few rotten apples in that barrel. As the debate over HMO reform has evolved, there has been a great deal of focus lately on the question of who decides what health care is medically necessary. Simply put, most health plans extol the fact that they pay for all health care that is medically necessary. Consumers find this reassuring as it suggests that if they need care, they will get it. What plans do not advertise nearly as extensively is that plans usually reserve for themselves the right to decide what is and what is not medically necessary.

On May 30, 1996, Congress got its first glimpse at this issue. On that day, a small, nervous woman testified before the House Commerce Committee. Her testimony was buried in the fourth panel at the end of a long day about the abuses of managed care. The reporters were gone, the television cameras had packed up, most of the original crowd had dispersed. She should have been the first witness that day, not the last. She told about the choices that managed care companies and self-insured plans are making every day when they determine medical necessity. Linda Peeno had been a claims reviewer for several HMOs and here is her story:

I wish to begin by making a public confession. In the spring of 1987, as a physician, I caused the death of a man.

She went on:

Although this was known to many people, I have not been taken to any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred. I was rewarded for this. It brought me an improved reputation on my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do what was expected of me, I exemplified the good company doctor, because I saved a half million dollars.

Well, Madam Speaker, as she spoke, a hush came over the room. The representatives of the trade associations who were still there averted their eyes. The audience shifted uncomfortably in their seats, both gripped and alarmed by her story. Her voice became husky and I could see tears in her eyes. Her anguish over harming patients as a managed care reviewer had caused this woman to come forth and bare her soul.

She continued:

Since that day I have lived with this act and many others eating into my heart and soul. For me a physician is a professional charged with the care or healing of his or her fellow human beings. The primary ethical norm is do no harm. I did worse. I caused death. Instead of using a clumsy bloody weapon, I used the simplest, cleanest of tools, my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. As the HMO would have me say, when any moral qualms arise, I was to remember, I am not denying care, I am only denying payment.

By this time, the trade association representatives were staring at the floor. The Congressmen who had spoken on behalf of the HMOs were distinctly uncomfortable, and the staff, several of whom subsequently became representatives of HMO trade associations, were thanking God that this witness had come at the end of the day.

Dr. Peeno's testimony continued:

At the time, this helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept escapist reasoning that allowed me to rationalize that decision. I accept my responsibility now for that man's death as well as the immeasurable pain and suffering many other decisions of mine caused.

She then went on to list the many ways that managed care plans deny care to patients but she emphasized one particular issue, the right to decide what care is medically necessary.

"There is one last activity that I think deserves a special place on this list, and that is what I call the smart bomb of cost containment, and that is medical necessity denials. Even when medical criteria is used, it is rarely developed in any kind of standard, traditional, clinical process. It is rarely standardized across the field. The criteria is rarely available for prior review by the physicians or members of the plan. We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry."

And after exposing her own transgressions, she closed by urging every-

one in that hearing room to examine their own conscience. I remember her saying this very well.

She said,

One can only wonder how much pain, suffering and death will we have before we have the courage to change our course? Personally, I have decided even one death is too much for me.

quiet. The chairman mumbled, "Thank you, doctor."

Linda Peeno could have rationalized her decisions as many do. "Oh, I was just working within guidelines." Or, "I was just following orders." Or, "You know, we have to save resources." Or, "This isn't about treatment, it's really just about benefits."

Dr. Peeno refused to continue this denial and will do penance for her sins the rest of her life by exposing the dirty little secret of HMOs determining medical necessity.

Madam Speaker, if there is only one thing our colleagues consider before voting on patient protection legislation, I hope it will be the fact that no amount of procedural protection or schemes for external review can help patients if the insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage. As Dr. Peeno so poignantly observed, insurers now routinely make treatment decisions by determining what goods and services they will pay for.

The difference between clinical decisions about medically necessary care and decisions about insurance coverage are especially blurred. Because all but the wealthy rely on insurance, the power of insurers to determine what coverage is medically necessary gives them the power to dictate professional standards of care.

Make no mistake, Madam Speaker. Along with the question of health plan liability, the determination of who should decide when health care is medically necessary is the key issue in patient protection legislation. Contrary to the claims of HMOs that this is some new concept, for over 200 years most private insurers and third-party payers have viewed as medically necessary those products or services provided in accordance with what we would call "prevailing standards of medical practice." This is the definition used in many managed care reform bills, including my own, the Managed Care Reform Act of 1999.

The courts have been sensitive to the fact that insurers have a conflict of interest because they stand to gain financially from denying care and have used themselves clinically derived professional standards of care to reverse insurers' attempts to deviate from standards. This is why it is so important that managed care reform legislation include an independent appeals panel with no financial interest in the outcome. A fair process of review, utilizing clinical standards of care, guarantees that the decision of the review board is made without regard to the financial interests of either the doctor

or the health plan. On the other hand, if the review board has to use the health plan's definition of medically necessary, there is no such guarantee.

In response to the growing body of case law and their own need to demonstrate profitability to shareholders, insurers are now writing contracts that threaten even this minimal standard of care. They are writing contracts in which standards of medical necessity are not only separated from standards of good practice but are also essentially not subject to review.

Let me give my colleagues one example out of many of a health plan's definition of medically necessary services. This is from the contractual language of one of the HMOs that some of you probably belong to: "Medical necessity means the shortest, least expensive or least intense level of treatment, care or service rendered or supply provided, as determined by us."

Contracts like this demonstrate that some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not to the patient's medical needs. So on the surface some would say, "Well, what is wrong with the least expensive treatment?"

Let me give my colleagues one example out of thousands. As a reconstructive surgeon before I came to Congress, I treated children with cleft lips and cleft palates. Clinical standards of care would determine that the best treatment is surgical correction. But under this HMO's contractual definition, that plan could limit coverage to a piece of plastic to fill in that hole in the roof of that kid's mouth. After all, that plastic obturator would be cheaper than a surgical correction.

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However, instead of condemning children to a lifetime of using a messy plastic prosthesis, the proper treatment, reconstruction utilizing that child's own tissue, will give that child the best chance at normal speech and a normal life.

Paradoxically, insurers stand to benefit from misguided legislative changes that displace case law. An example is the legislation that passed this House last year and the GOP bill in the Senate that would have granted insurers the explicit power to define medical necessity without regard to current standards of medical practice. This would have been accomplished by allowing them to classify as medically unnecessary any procedures not specifically to be found necessary by the insurer's own technical review panel.

Think of that, Madam Speaker. The legislation that passed, the Republican legislation that passed this House last year explicitly gave to the HMOs, the ones that were abusing medical necessity in the first place, the ability by legislative language to determine exactly what they thought medical necessity should be, and the Senate bill

would have even given insurers the power to determine what evidence would be relevant in evaluating claims for coverage, and would have permitted insurers to classify some coverage decisions as exempt from administrative review.

And I know, Madam Speaker, that many of our colleagues who supported those bills last year had no idea of the implications of the medical necessity provisions that were in those bills. Specifically, insurers now want to move away from clinical standards of care applied to particular patients, and they want to move to standards linking medical necessity to what are called population studies. On the surface this may seem sort of scientific or rational, but as a former medical reviewer myself who worked for many insurers, large and small, let me explain why I think it is critical that we stick with medical necessity as defined by, quote, clinical standards of care, unquote.

First, sole reliance on broad standards from generalized evidence is not good medical practice; second, there are practical limits to designing studies that can answer all clinical questions; and, third, most studies are not of sufficient scientific quality to justify overruling clinical judgment.

Now let me explain these points in a little more detail, and I also recommend an article on these shortcomings by Rosenbaum in the January 21, 1999, edition of the *New England Journal of Medicine*.

First, while it may sound counter intuitive, it is not good medicine to solely use outcome-based studies of medical necessity even when the science is rigorous. Why is this? Well, it is because the choice of the outcome is inherently value laden. The medical reviewer for the HMO is likely, as shown by the above-mentioned contract, to consider cost the essential value. But what about quality?

As a surgeon I treated many patients with broken fingers simply by reducing the fracture and splinting the part. For most patients this would restore adequate function. But for the musician who needs a better range of motion surgery might be necessary. Which outcome should be the basis for the decision about insurance coverage? Playing the piano or routine functioning?

My point is this: Taking care of patients involves much individualization and variation. Definition of medical necessity must be flexible enough to take into account the needs of each patient. One-size-fits-all outcomes make irrelevant the doctor's knowledge of the individual patient and is bad medicine, period.

Second, there are practical limitations on basing medical necessity on what are called generalized evidence, particularly as it applies to HMOs. Much of medicine is a result of collective experience, and many basic medical treatments have not been studied rigorously. Furthermore, aside from a handful of procedures that are not ex-

plicitly covered, most care is not specifically defined in health plans because of the number of procedures and the circumstances of their application, which are limitless.

In addition, by their very nature many controlled clinical trials study treatments in isolation. They are controlled studies, whereas physicians need to know the benefits of one type of treatment over another. Prospective, randomized comparison studies, on the other hand, are expensive. Given the enormous number of procedures and individual circumstances, if coverage is limited to only those that have scientifically sound generalized outcomes, care could be denied for almost all conditions. And come to think of it, Madam Speaker, maybe that is why the HMOs are so keen on getting away from prevailing standards of care.

Third, Madam Speaker, the validity of HMO guidelines and how they are used I think is very much open to question. Medical directors of HMOs were asked to rank the sources of information they use to make medical decisions. Industry guidelines generated by the trade associations representing health plans ranked ahead of information from national experts, government documents and NIH consensus conferences. The most highly ranked respected source, medical journals, was used by HMO directors less than 60 percent of the time.

And industry guidelines are frequently done by a group called Milliman and Robertson, a strategy shop for the HMO industry. This is the same firm that championed "drive through" deliveries and outpatient mastectomies. Many times these practice guidelines are not grounded in science but are cookbook recipes derived by actuaries to reduce health care costs, plain and simple.

Let me give two examples of the errors of these guidelines. A National Cancer Institute study released in June found that women receiving outpatient mastectomies face, quote, significantly higher, unquote, risks of being rehospitalized and have a higher risk of surgery-related complications like infections and blood clots. In 1997 a study published in the *Journal of the American Medical Association* showed that babies discharged within a day of birth faced increased risk of developing jaundice, dehydration and dangerous infections.

So there we have drive-through deliveries and outpatient mastectomies. The objectivity of medical decision-making requires that the results of studies be open to peer review. Yet much of the decision-making by HMOs is based on unpublished, proprietary, and unexamined methods and data. Such secret and potentially biased guidelines simply cannot be called scientific.

Now that is not to say that outcome-based studies do not make up a part of how clinical standards of care are determined, because they do. But we are

all familiar with the ephemeral nature of new scientific studies such as those on the supposed dangers of alar.

Now clinical standards of care do take into account valid and replicable studies in the peer reviewed literature as well as the results of professional consensus conferences, practice guidelines based on government-funded studies, and guidelines prepared by insurers that have been determined to be free of any conflict of interest. But most importantly, they also include the patient's individual health and medical information and the clinical judgment of the treating physician.

The importance of this issue, Madam Speaker, cannot be over emphasized, and it can be found in a recent decision by the Tenth Circuit Court of Appeals. In the case *Jones v. Kodak*, the name Jones is particularly appropriate, I might add, because after this decision other health plans will rush to keep up with what their competitors are doing to the Joneses of this world. In any event, in *Jones v. Kodak* the Tenth Circuit Court of Appeals showed how ERISA, the Employee Retirement Income Security Act, and a clever health plan can work in tandem to keep patients from getting needed medical care.

Now the facts are relatively simple of this case. Mrs. Jones received health care through her employer, Kodak. The plan covers in-patient substance abuse treatment when medically necessary. Here we are, back at the medically necessary issue again. The determination as to whether a particular substance abuse service is medically necessary is made by American Psych Management, APM.

American Psych Management reviewed a request for in-patient substance abuse treatment and found that Mrs. Jones did not meet APM's protocol for in-patient mental health hospitalization. So the family pursued the case further, eventually persuading the health plan to send the case to an independent medical expert of the plan's own choosing for review.

The reviewer agreed that Mrs. Jones did not qualify for the benefit under the criteria established by the plan. But he observed that, quote, these criteria are too rigid and do not allow for individualization of case management, unquote. In other words, the criteria were not appropriate to Mrs. Jones' condition. But his hands were tied. The reviewer was unable to reverse APM's original decision.

So, Madam Speaker, Mrs. Jones sued for the failure to pay the claim. In affirming the trial court's decision to grant summary judgment to the defendants, the Tenth Circuit Court of Appeals held the following:

"ERISA's disclosure provisions do not require that the plan summary contained particularized criteria for determining medical necessity."

They also held: "The unpublished APM criteria were part of the plan's terms. Because we consider the APM

criteria a matter of plan design and structure, rather than implementation, we agree that a court cannot review them."

So what does this all mean in layman's terms? Well, it means that a plan does not have to disclose the treatment guidelines or the protocols it uses to determine whether or not a patient should get care, and furthermore, any treatment guidelines used by the plan would be considered part of the plan design and thus are not reviewable by the court.

The implications of this decision, Madam Speaker, are, in a word, breathtaking. *Jones v. Kodak* provides a virtual road map to enterprising health plans of how to deny payment for medically necessary care. The decision is a clear indication of why we need Federal legislation to ensure that treatment decisions are based on good medical practice and take into consideration the individual patient circumstances.

Under *Jones v. Kodak*, health plans do not need to disclose to potential or even current enrollees the specific criteria they used to determine whether a patient will get treatment. There is no requirement that a health plan use guidelines that are applicable or appropriate to a particular patient's case.

Despite these limitations, *Jones* compels external reviewers to follow the plan's inappropriate treatment guidelines because to do otherwise would violate the sanctity of ERISA. And finally, plans following their own criteria, no matter how misguided, are shielded from court review since, as the court in the *Jones* case noted, this is a plan design issue and is therefore not reviewable under ERISA.

If Congress, through patient protection legislation, does not act to address this issue, many more patients will be left with no care and no recourse. *Jones v. Kodak* sets a chilling precedent making health plans and the treatment protocols untouchable. The case in effect encourages health plans to concoct rigid and potentially unreasonable criteria for determining when a covered benefit is medically necessary.

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That way, they can easily deny care and cut costs, all the while insulated from responsibility for the consequences of their actions.

For example, a plan could promise to cover cleft lip surgery for those born with that birth defect, but they could put in undisclosed documents that the procedure is only medically necessary once the child reaches the age of 16; or that coronary bypass operations are only medically necessary for those who have previously survived two heart attacks. Logic and principles of good medical practice would dictate that that is not sound health care, but this case affirmed that health plans do not have to consider medicine at all. They can be content to consider only the bottom line.

Unless Federal legislation addresses this issue, patients will never be able to find out what criteria their health plans use to provide care and external review. They will be unable to pierce those policies and reach independent decisions about medical necessity of proposed treatment using clinical standards of care. ERISA will prevent courts from engaging in such inquiries too. The long and the short of the matter is that, increasingly, sick patients will find themselves without proper treatment and without any recourse.

To illustrate these dangers, let me give you a hypothetical case. Imagine a plan that proudly states in its enrollment materials that it has the best mental health benefits in the field, and, in fact, their benefit package includes longer inpatient mental health benefits than other area insurers. But the plan contracts with a managed mental health care company who states that inpatient admission is only available if a person has unsuccessfully attempted suicide three times. This fact is not made known to the employer and it is not made known to the employee, who, by the way, may not have any option in terms of which plan he chooses.

So let us say an employee's son swallows a bottle of sleeping pills and is taken to the ER, where he is revived. Two days later the son tries to drink Drano, but is caught by his mother before ingesting any. The family calls the plan, asks for an inpatient mental health admission, but, using the "three tries" criteria, coverage is denied.

Unable to afford inpatient care themselves, the family returns home, hoping to keep a careful watch on this son, maybe to get him some outpatient counseling. But 3 days later, you know, three times a charm, the boy sneaks into the woods and, with a kitchen knife, he slits his wrists and bleeds to death.

What remedies would that family have? According to the court in the *Jones* case, none. The plan followed its own criteria. The *Jones* decision makes it clear that the written criteria for medical necessity are considered part of the contract, even if not disclosed to that family, and, no matter how unreasonable the criteria may seem to an independent review panel, that body is bound to decide the case based on whether the plan followed its own definition of medical necessity. And even if the plan's criteria for defining medical necessity is arbitrary and contrary to common medical practice, a court cannot review that matter because it is an issue of plan design.

Madam Speaker, the *Jones* decision is an HMO road map on how to deny medically necessary care at no risk, and Congress must pass legislation, and the sooner the better, to ensure that external reviewers are not bound by the plan's concocted definitions of medical necessity. Anything less than that is a mockery of legislation promising patients an independent external review.

Madam Speaker, I have introduced legislation, H.R. 719, the Managed Care Reform Act, which addresses the very real problems in managed care. It gives patients meaningful protections, it creates a strong and independent review process, and it removes the shield of ERISA which health plans have used to prevent State court negligence actions by enrollees who are injured as a result of that plan's negligence.

This bill has received a great deal of support and has been endorsed by consumer groups like the Center for Patient Advocacy and the American Cancer Society and the American Academy of Family Physicians. It has received strong words of support from groups like the America Medical Association and multiple other organizations.

Madam Speaker, we need to move this legislation. Every day that we wait, we have a similar circumstance to what happened to little Baby James. But I want to focus on one small aspect of my bill, specifically the way in which it addresses the issue, the Employee Retirement Income Security Act.

It is alarming to me that ERISA combines a lack of effective regulation of health plans with a shield for health plans that largely gives them immunity from liability for negligent actions. Personal responsibility has been a watchword for this Republican Congress, and this issue should be no different. Health plans that recklessly deny needed medical service should be made to answer for their conduct. Laws that shield entities from their responsibility only encourage them to cut corners. Congress created that ERISA loophole, and Congress should fix it.

My bill has a new formulation on the issue of health plan liability. I continue to believe that health plans that make negligent medical decisions should be accountable for their actions, but a winning lawsuit is of little consolation to a family who has lost a loved one. The best HMO bill assures that health care is delivered when it is needed.

Madam Speaker, I also believe that the liability should attach to the entity that is making medical decisions. Many self-insured companies contract with large managed care plans to deliver care. If the business is not making those discretionary decisions, they should not face liability, and that is a provision in my bill. But if they cross the line and they determine whether a particular treatment is medically necessary in a given case, then they are making medical decisions and they should be held accountable for their actions.

To encourage health plans to give patients the right care without going to court, my bill provides for both an internal and external appeals process that is binding on the plan, and an external review could be requested by either the patient or the plan.

I foresee some circumstances where a patient is requesting an obviously in-

appropriate treatment, like laetrile for cancer, and the plan would want to send the case to an external review that will back up their decision and give them an effective defense if they are ever dragged into court to defend that decision.

When I was discussing this idea with the CEO of my own Blue Cross plan back in Iowa, he expressed support for this strong external review. In fact, he told me that Iowa Wellmark is instituting most of the recommendations of the President's Commission on Health Care Quality and he did not foresee any premium increases as a result. Mostly what it meant, he told me, was tightening existing safeguards and policies. He also told me that he would support a strong independent external review system like the one in my bill, but, he cautioned, if we did not make the decision and are just following the recommendation of the review panel, then we should not be liable for punitive damages.

I agree with that. Punitive damage awards are meant to punish outrageous and malicious conduct. If a health plan follows the recommendation of an independent review board composed of medical experts, it is tough to figure out how they have acted with malice. So my bill provides health plans with a complete shield from punitive damages if they promptly follow the recommendation of an external review panel.

That, I think, is a fair compromise on the issue of health plan liability. I sure suspect that Aetna wishes they had had an independent peer panel available even with the binding decision on care when it denied care to David Goodrich. Earlier this year a California jury handed down a verdict of \$116 million in punitive damages to his widow. If Aetna or the Goodriches had had the ability to send the denial of care to an external review, they could have avoided the courtroom; but, more importantly, David Goodrich might still be alive today.

That is why my plan should be attractive to both sides. Consumers get a reliable, quick, external appeals process which will help them get the care they need. They can go to court to collect economic damages like lost wages and future medical care, and non-economic damages like pain and suffering. If the plan fails to follow the external review decision, the patient can then sue for punitive damages.

Health insurers, whose greatest fear is \$50 million or \$100 million punitive damage awards, can shield themselves from those astronomical awards, but only if they follow the recommendations of an independent review panel, which is free to reach its own decision on what care is medically necessary.

I have heard from insurers who say that premiums will skyrocket. I think there is adequate evidence that that would not be the case. Last year the CBO estimated a similar proposal, which did not include the punitive

damages relief of my bill, would only increase premiums around 2 percent over 10 years, and when Texas passed its own liability law 2 years ago, the Scott & White Health Plan estimated premiums would have to increase just 34 cents per member per month to cover the cost. Those are hardly alarming figures. The low estimate by Scott & White seems accurate, since only one suit has been filed against the Texas health plan since the law was passed. That is far, Madam Speaker, from the flood of litigation that the opponents predicted.

I have been encouraged by the positive response my bill has received, and think that this should be the basis for a bipartisan bill this year. In fact, the Hartford Courant, a paper located in the heart of the insurance country, ran a very supportive editorial on my bill by John MacDonald.

Speaking of the punitive damages provision, McDonald called it "a reasonable compromise." He urged insurance companies to embrace the proposal as "the best deal they see in a long time."

Madam Speaker, I include the full text of the editorial by John MacDonald for the RECORD at this point.

[From the Hartford Courant, Mar. 27, 1999]

A COMMON-SENSE COMPROMISE ON HEALTH CARE

(By John MacDonald)

U.S. Rep. Greg Ganske is a common-sense lawmaker who believes patients should have more rights in dealing with their health plans. He has credibility because he is a doctor who has seen the runaround patients sometimes experience when they need care. And he's an Iowa Republican, not someone likely to throw in with Congress' liberal left wing.

For all those reasons, Ganske deserves to be heard when he says he has found a way to give patients more rights without exposing health plans to a flood of lawsuits that would drive up costs.

Ganske's proposal is included in a patients' bill of rights he has introduced in the House. Like several other bills awaiting action on Capitol Hill, Ganske's legislation would set up a review panel outside each health plan where patients could appeal if they were denied care. Patients could also take their appeals to court if they did not agree with the review panel.

But Ganske added a key provision designed to appeal to those concerned about an explosion of lawsuits. If a health plan followed the review panel's recommendation, it would be immune from punitive damage awards in disputes over a denial of care. The health plan also could appeal to the review panel if it thought a doctor was insisting on an untested or exotic treatment. Again, health plans that followed the review panel's decision would be shielded from punitive damage awards.

This seems like a reasonable compromise. Patients would have the protection of an independent third-party review and would maintain their rights to go to court if that became necessary. Health plans that followed well-established standards of care—and they all insist they do—would be protected from cases such as the one that recently resulted in a \$120.5 million verdict against an Aetna plan in California. Ganske, incidentally, calls that award "outrageous."

What is also outrageous is the reaction of the Health Benefits Coalition, a group of business organizations and health insurers that is lobbying against patients' rights in Congress. No sooner had Ganske put out his thoughtful proposal than the coalition issued a press release with the headline: Ganske Managed Care Reform Act—A Kennedy-Dingell Clone?

The headline referred to Sen. Edward M. Kennedy, D-Mass., and Rep. John D. Dingell, D-Mich., authors of a much tougher patients' rights proposal that contains no punitive damage protection for health plans.

The press release said: "Ganske describes his new bill as an affordable, common sense approach to health care. In fact, it is neither: It increases health care costs at a time when families and businesses are facing the biggest hike in health care costs in several years."

There is no support in the press release for the claim of higher costs. What's more, the charge is undercut by a press release from the Business Roundtable, a key coalition member, that reveals that the Congressional Budget Office has not estimated the cost of Ganske's proposal. The budget office is the independent reviewer in disputes over the impact of legislative proposals.

So what's going on? Take a look at the coalition's record. Earlier this year, it said it was disappointed when Rep. Michael Bilirakis, R-Fla., introduced a modest patients' rights proposal. It said Sen. John H. Chafee, R-R.I., and several co-sponsors had introduced "far left" proposal that contains many extreme measures. John Chafee, leftist? And, of course, it thinks the Kennedy-Dingell bill would be the end of health care as we know it.

The coalition is right to be concerned about costs. But the persistent No-No-No chorus coming from the group indicates it wants to pretend there is no problem when doctor-legislators and others know better.

This week, Ganske received an endorsement for his bill from the 88,000-member American Academy of Family Physicians. "These are the doctors who have the most contact with managed care," Ganske said. "They know intimately what needs to be done and what should not be done in legislation."

Coalition members ought to take a second look. Ganske's proposal may be the best deal they see in a long time.

Madam Speaker, it is also important to state what this bill does not do to ERISA plans. It does not eliminate ERISA or otherwise force large multistate health plans to meet the individual consumer protection and benefit mandates of each State. This is a very important point.

Just last week I had representatives of a large national company, headquartered in the upper Midwest, in my office. They urged me to rethink my legislation because, they alleged, it would force them to comply with the benefit mandates of each State and that the resulting rise in costs would force them to discontinue offering health insurance to employees.

Frankly, Madam Speaker, I was stunned by their comments, because their fears were totally incorrect and misplaced. It is true that my bill would lower the shield of ERISA and allow plans to be held responsible for their negligence; but, Madam Speaker, it would not alter the ability of group health plans to design their own benefits package.

Let me be absolutely clear on this point: The ERISA amendments in my bill would allow States to pass laws to hold health plans accountable for their actions. It would not allow States to subject ERISA plans to a variety of health benefit mandates or additional consumer protections.

Madam Speaker, there are other pressing issues that require our prompt attention. In particular, the crisis in the Balkans is becoming a humanitarian tragedy of unspeakable proportions. Congress should exercise its constitutional responsibility and decide whether to authorize the use of ground troops, and I am very pleased Congressman CAMPBELL will be bringing this to the floor tomorrow.

However that vote turns out though, we must not turn our backs on our own domestic problems. It would be irresponsible of Congress to ignore the people that are being harmed daily by medically negligent decisions by HMOs around the country. The need for meaningful patient protection legislation continues to fester every day.

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And to repeat, Madam Speaker, I have recently heard that the leadership of the House is not going to allow debate on patient protection until October at the earliest. Why the delay? We could move this in committee next month. We could bring this to the floor before the August recess, and we should. The clock is ticking, Madam Speaker, and patients' lives are on the line.

Madam Speaker, I look forward to working with all of my colleagues to see that passage of real HMO reform legislation is an accomplishment of the 106th Congress that we can all go home and be proud about. I urge my colleagues to cosponsor H.R. 719, the Managed Care Reform Act of 1999.

ALTERNATIVE SOLUTIONS FOR SOLVING THE CONFLICT IN KOSOVO

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

Mr. WELDON of Pennsylvania. Madam Speaker, I rise this evening to continue the discussion on the situation that we face in Kosovo, and what I think is an historic opportunity that hopefully we have not yet missed to solve that crisis without putting our troops into further harm's way.

In fact, today, Madam Speaker, the President called up 2,116 military reserve troops to active duty and authorized 33,000 reservists to be called up in the near future. The air war continues, the bombing and the destruction continues, yet the resolve of the Serbs seems to also continue with no end in sight.

Many of us are concerned that we do not have a solid plan to end the con-

flict and that we do not have a strategy to win the conflict. Therefore, this continuing escalation of the aerial assault on the former Yugoslavia causes a great deal of concern for our colleagues on both sides of the aisle.

Tomorrow, Madam Speaker, we are going to be asked to vote on one of several alternatives, including the War Powers Act resolution to withdraw our troops from the former Yugoslavia. A second alternative is to declare war against Yugoslavia, and a third option is an alternative that would have us say to the administration that no dollars can be expended for the insertion of ground troops unless the Congress has given its approval.

Now, we all know, Madam Speaker, that these resolutions may or may not pass, but this administration will continue on its course. They have not consulted with the Congress in the past; I do not think that is going to change. I think we are going to continue to see a movement that is aggressively pursuing the aerial campaign and eventually, perhaps, the insertion of ground troops. If that time comes, Madam Speaker, we face some very dangerous prospects.

One only has to look at history to understand how the Serbs stood up against Hitler from the period of 1941 to 1945. Even though the Germans had not only their 22 divisions but the help of 200,000 Croatians, Slovenian and Bosnian Muslim volunteer auxiliaries, they were able to repel Hitler, they were able to retain the control of their land and, in fact, in the end, they won a victory.

Now, I am not saying that if we get involved in a direct confrontation with Serbia that we cannot win. Make no mistake about it, we can. We have the finest fighting force in the world, and with the help of our NATO allies, I am sure we could prevail, but it would not be without cost. Furthermore, Madam Speaker, what really concerns me is the position that perhaps we will put the Russians in.

Russia has already indicated it will not honor our naval blockade that is designed to prevent additional oil supplies from getting into Serbia to resupply the military and the economy. Russia could be put into a position where it is asked to protect the resupply efforts to get food and necessary materials into Serbia. In either of those cases, we set up a situation where the United States and Russia could come into direct conflict, perhaps even hostile action, our troops against theirs, the NATO troops against the Russians and the Serbs. That would be catastrophic. Again, not because I do not think we would win that battle, because I think we would. But the toll that it would take in loss of life and the ending result of us then having to control the former Yugoslavia and partition it and the extensive amount of investment that we would have to make leads me to believe that that is not the right course for us to be taking.