adopt here in this body policies that will make it easier for Americans to save for the future, that is good for their security when they retire. It is good for economic growth in this Nation. It makes sense. It is not a partisan issue. It is a bipartisan issue. I urge this body during this session to take up legislation that will make it easier for Americans to save for their future. The Portman-Cardin bill is a major step forward in this direction. We hope that we would consider it this year.

Mr. PORTMAN. I would urge my colleagues on both sides of the aisle to talk to the gentleman from Maryland, talk to me. H.R. 1102 is the name of the legislation. We have a number of cosponsors. We are looking for more. If we can come together again on a bipartisan basis to solve this problem and get this legislation passed, it will make the difference in people's lives. It will allow for millions of Americans to have real security in retirement rather than mere subsistence. It is something that we can do this year. Of course we all want to solve Social Security's problems. That may be a little more difficult to do in this environment. But this is one where we should be able to come together to provide for people to be able to save more for their retirement even outside of Social Security, even while we are working on the Social Security problem.

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

(Mr. HILL addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

PARLIAMENTARY ELECTIONS IN ARMENIA

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

Mr. PALLONE. Mr. Speaker, on Sunday, May 30, the Republic of Armenia will hold parliamentary elections. In these last 2 weeks leading up to election day, the parties and candidates are intensifying their campaigns and are holding rallies, meetings and using free TV air time as well as paid commercials to get their message out to the voters. Both domestic and international observers will closely scrutinize the conduct of the election to ensure that it is free and fair. Armenia's Central Elections Commission has promised equal treatment for all parties and has vowed to penalize anyone who commits illegal or fraudulent acts connected to the election.

Mr. Speaker, we Americans may take for granted the idea of free and fair elections, but in Armenia as a former captive nation under the Soviet Union, the progress of democracy and the establishments of the institutions of a civil society in less than a decade of independence is nothing short of remarkable. Furthermore, Mr. Speaker, given the fact that many of Armenia's neighbors are ruled by authoritarian governments, some of which maintain a hostile and aggressive attitude, the determination of the Armenian people to work towards a democratic political system is all the more impressive.

Armenian voters last went to the polls in March of 1998 to elect a President. The winner of that election, President Robert Kocharian, was here in Washington last month as part of the NATO summit. He also came to Capitol Hill to meet with Members of Congress to discuss the prospects for U.S.-Armenia relations and our role in promoting stability and economic development in the Caucasus region. Armenia's central location in the heart of this region at the crossroads of Europe, Russia, the Middle East and Central Asia will make it an increasingly important country for the U.S. strategic considerations in the 21st century.

Mr. Speaker, for a country with less than 4 million people living in an area about the size of the State of Maryland, Armenia has an extremely diverse group of political parties representing a wide range of ideologies. More than 800 individual candidates and 21 political parties are vying for 131 seats in the parliament; 75 seats will be contested in single-candidate constituencies, while 56 seats are reserved for a system of proportional representation.

According to a recent report, 11 political parties and blocs have used the free TV air time that has been allotted to them. Media outlets representing diverse ideologies are covering the elections. For the first time, the campaign and election will be covered on the Internet. Paid political advertisements for this election cycle have exceeded the levels of all previous election campaigns. A survey by the Armenian Sociological Association indicated that voter turnout would be as high as 75 percent, although other polls suggest figures could be somewhat lower than that. The polls indicate that at least six parties and blocs would be able to garner the 5 percent threshold of votes needed to be represented in the Parliament. The major issue is expected to be the economy.

Mr. Speaker, I just want to stress that in the first few elections held in the first few years after Armenia became a democracy, there were admittedly some problems. But last year's presidential elections showed the world that Armenia has made significant progress in just a few years despite the legacy of 70 years of Communist dictatorship. After the resignation of Armenia's first President, Levon Ter-Petrosian, in early 1998, the transition was handled in an orderly manner according to the nation's constitution. The presidential election conducted in two rounds was peaceful and well-organized, and the legitimacy of the outcome was accepted by the vast majority of observers inside and outside Armenia.

Later this month, Armenia will once again find itself under heavy international scrutiny because of the elections. The Organization for Security and Cooperation in Europe on April 26 set up a monitoring mission with 15 long-term observers deployed around the country to monitor the election campaign and administrative preparation, and to assess the implementation of the new electoral code.

Mr. Speaker, I am confident that the Armenian people will demonstrate once again during this election on May 30 their commitment to building a society based on civility, the rule of law and tolerance for each other's opinions. This election I think will go far once again to show the progress of Armenia's democracy.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

(Ms. JACKSON-LEE addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

MANAGED CARE REFORM

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 as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, here it is, the middle of May, and no movement by the House leadership on fixing HMO abuses. Time is passing by quickly this year. Yet the chairmen of the committees of jurisdiction have done virtually nothing to move this forward.

Mr. Speaker, I have worked on this problem along with many others in this House for over 4 years. We have had debates and debates and debates. The issues are laid out. They have been laid out in a debate last year. There is no excuse why we should not move managed care reform to the floor soon. There is a real reason for this. There are people that are being injured by HMO abuses today.

Let me give my colleagues a couple of examples of people who have had problems with their HMOs. A few years ago, a young woman was hiking in the Shenandoah mountains just a little ways west of Washington, D.C. She fell off a 40 foot cliff. She was lucky she did not fall into the rocky pond where she might have drowned. But she fractured her skull, she broke her arm, and she broke her pelvis. She is laying there at the bottom of this 40 foot cliff semicomatose. Fortunately a hiking companion had a cellular phone and they airlifted her into the emergency room. She was treated in the hospital, in the intensive care unit for quite a while, was in the hospital I think for over a month. When she was discharged, she found that her HMO was not going to pay her bill.

Why, Mr. Speaker? The HMO said this young woman, Jackie Lee is her name, did not phone ahead for prior authorization.

Now, think about that. Was she supposed to know that she was going to fall off that 40 foot cliff? Or maybe when she was laying there, semicomatose at the bottom of the cliff with a broken skull, a broken arm, a broken pelvis, she was supposed to rouse herself, maybe with her nonbroken arm pull out of her pocket a cellular phone and dial a 1–800 number to her HMO and say, ''Hey, you know, I just fell off a 40 foot cliff. I need to go to the hospital.''

□ 2130

Mr. Speaker, fortunately she was able to get some help from her State insurance commissioner, and she was able to get that HMO's decision reversed, but as my colleagues know, Mr. Speaker, a lot of people would not have that basic protection because most of the people in this country receive their insurance through their employer, and when they get their insurance through their employers, their State insurance commissioner does not have any jurisdiction because of a past Federal law.

Now, if my colleagues think the case of Jackie Lee was bad, let me tell my colleagues about another case. This was about a little 6-month-old boy named James Adams.

A couple years ago, about 3:00 in the morning, James' mother, Lamona, was taking care of him. He was pretty sick. He had a temperature of over 104. He was crying, he was moaning. As a mother can tell, her little baby was really sick. So Lamona phones that 1–800 number for her HMO. She explains: ''My little baby is sick and needs to go to the emergency room soon.''

She gets an authorization from this bureaucrat, but the authorizer says, ''I'm only going to allow you to take little Jimmy to the Shriner's Hospital.''

Lamona says, ''Well, where is that?''

This disembodied voice a thousand miles away says, ''Well, I don't know. Find a map.''

Well, Lamona, the Adams family, lived way to the east of Atlanta, Georgia. The hospital that they were authorized to go to was on the other side of Atlanta, 70-some miles away.

It is a stormy night, so Mr. And Mrs. Adams wrap up little Jimmy, get in the car and start their trek. About halfway there, as they are going through Atlanta, Georgia, they pass Baptist Hospital, Piedmont, Emory Hospital, all with world-renowned medical facilities and emergency rooms that could have taken care of little Jimmy Adams. But they do not have an authorization from their insurance company, from their HMO, and they know that if they stop, then they are going to be stuck with the bill which could be thousands of dollars.

So, not being medical professionals, they think, ''Well, we can push on.'' About 23 miles from the Shriner's Hospital little Jimmy has a cardiac arrest in the car. Picture his dad driving along frantically trying to find the hospital, picture his mother trying to save her little baby's life.

Turns out that little Jimmy is a pretty tough guy. They manage to eventually get him to the hospital alive. But because of that delay in treatment, that cardiac arrest, little Jimmy ends up with gangrene of both hands and both feet, and both hands and both feet have to be amputated, all because of the delay caused by that medical decision that that HMO made.

I talked to Jimmy's mother about a month ago, asked her about how little Jimmy was coming along now. As my colleagues know, despite wonderful prostheses that we have now, it is safe to say that Jimmy is not going to be an athlete, and I know that when he grows up and gets married he is not going to be able to caress the check of the woman that he loves with his hand because he has bilateral hook prostheses. He is able to pull on his leg prostheses now with his arms' stumps, but he cannot get on both bilateral arm prostheses without a lot of help from his parents.

Jimmy will live the rest of his life without his hands and his feet, and do you know that in a similar situation, if you receive your insurance through your employer and your HMO has made that type of medical decision that has resulted in the loss of the hands and feet of your little baby, that that HMO by prior Federal law is liable for nothing? Hard to believe?

That is all the result of a law that Congress passed 20-some years ago that gives total immunity for liability to an HMO that makes that type of devastating medical decision that has resulted in loss of hands and feet or maybe even loss of life. The only thing under Federal law that that plan is responsible for is the cost of the treatment that would be rendered, and after all, Jimmy made it to the hospital, so he got his treatment.

Turns out a Federal judge looked at the margin of safety for that HMO, and I will never forget the quote. The judge said the margin of safety for that HMO in this instance was razor thin, quote, unquote; I would say, Mr. Speaker, about as razor thin as the scalpel that had to cut off little Jimmy's hands and feet.

Mr. Speaker, I am far from alone in holding that view that we need real HMO reform. Last week, for example, Paul Elwood gave a speech at Harvard University on health care quality, HMO quality. Now, Mr. Speaker, Paul Elwood is not exactly a household name, but he is considered the father of the HMO movement.

Elwood told a surprised group of people that he did not think health care quality would improve without government imposed protections. Market forces, he told the group, quote, ''will never work to improve quality, nor will voluntary efforts by doctors and health plans.'' Nor will voluntary efforts by doctors and health plans.

Elwood went on to say, and I quote: ''It doesn't make any difference how powerful you are or how much you know, patients get atrocious care.''

Remember, this is the father of the HMO movement. He is saying patients get atrocious care and can do very little about it.

He goes on: ''I have increasingly felt that we've got to shift the power to the patient. I am mad,'' he said, ''in part because I've learned that terrible care can happen to anyone.''

Mr. Speaker, maybe Paul Elwood was thinking about Jackie Lee. Maybe he was thinking about little Jimmy Adams.

Mr. Speaker, this is not the commentary of a mother whose child was injured by her HMO's refusal to give appropriate care. It is not the statement of a doctor who could not get requested treatment for a patient. Mr. Speaker, these words suggesting that consumers need real protections from HMO abuses come from the father of managed care.

Now I am tempted to stop here and just let his words speak for themselves, but I think it is important to share with my colleagues an understanding of the flaws in the health system that led Paul Elwood to reach his conclusion.

Cases involving patients who lose their limbs or even their life are not isolated examples. They are not just mere, quote, anecdotes, unquote. I mean those anecdotes, if they have a finger, and you prick it, they bleed.

Mr. Speaker, on May 4 USA Today ran an excellent editorial on this very subject. It was entitled: ''Patients Face Big Bills as Insurers Deny Emergency Claims.'' After citing a similar case involving a Seattle woman, USA Today made some telling observations. Quote: ''Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford.''

That was exactly the situation that Mr. and Mrs. Adams were in as they were driving along the highway with a really sick infant. They were not trained medical professionals. They knew if they stopped, though, at that unauthorized emergency room, they were going to be stuck with the bill.

The editorial goes on to say, quote: ''All patients are put at risk if hospitals facing uncertainty about payment are forced to cut back on medical care,'' and this is hardly an isolated problem. The Medicare Rights Center in New York reported that 10 percent of complaints for Medicare HMOs related to denials for emergency room bills.

The editorial noted that about half the States have enacted a prudent lay person definition for emergency care in the last 10 years, and Congress has passed such protection in Medicare and in Medicaid, but nevertheless the USA Today editorial concludes that the current patchwork of laws would be much strengthened by passage of a national prudent lay person standard that applies to all Americans. And that is why

in my bill, the HMO Reform Act of 1999, and the bill of the gentleman from Michigan (Mr. DINGELL), the Patient Bill of Rights, we have a provision in there that would have prevented the type of occurrence that we had with little Jimmy Adams, because it says if the average lay person would think that this is truly an emergency, you can take that patient or you can go yourself directly to the emergency room and the HMO has to pay the bill.

The final sentence of that editorial from USA Today reads, quote: ''Patients in distress should not have to worry about getting socked with big health bills by firms looking only at their bottom line.''

Mr. Speaker, I ask that the full text of this editorial be included in the RECORD at this point:

[From USA Today, May 4, 1999]

PATIENTS FACE BIG BILLS AS INSURERS DENY EMERGENCY CLAIMS

Early last year, a Seattle woman began suffering chest pains and numbness while driving. The pain was so severe that she pulled into a fire station seeking help, only to be whisked to the nearest hospital, where she was promptly admitted.

To most that would seem a prudent course of action. Not to her health plan. It denied payment because she didn't call the plan first to get ''pre-authorized,'' according to an investigation by the Washington state insurance commissioner.

The incident is typical of the innumerable bureaucratic hassles patients confront as HMOs and other managed care companies attempt to control costs. But denial of payment for emergency care presents a particularly dangerous double whammy:

Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford.

All patients are put at risk if hospitals, facing uncertainty about payment, are forced to cut back on medical care.

Confronted with similar outrages a few years ago, the industry promised to clean up its act voluntarily, and it does by and large pay up for emergency care more readily than it did a few years ago. In Pennsylvania, for instance, denials dropped to 18.6% last year from 22% in 1996.

That's progress, but not nearly enough. Several state insurance commissioners have been hit with complaints about health plans trying to weasel out of paying for emergency room visits that most people would agree are reasonable—even states that mandate such payments. Examples:

Washington's insurance commissioner sampled claims in early 1998 and concluded in an April report that four top insurers blatantly violated its law requiring plans to pay for ER care. Two-thirds of the denials by the biggest carrier in the state—Regence BlueShield—were illegal, the state charged, as were the majority of three other plans' denials. The plans say those figures are grossly inflated.

The Maryland Insurance Administration is looking into complaints that large portions of denials in that state are illegal. In a case reported to the state, an insurance company denied payment for a 67-year-old woman complaining of chest pain and breathing problems because it was ''not an emergency.''

Florida recently began an extensive audit of the state's 35 HMOs after getting thousands of complaints, almost all involving denials or delays in paying claims, including those for emergency treatments.

A report from the New York-based Medicare Rights Center released last fall found that almost 10% of those who called the center's hotline complained of HMO denials for emergency room bills.

ER doctors in California complain that Medicaid-sponsored health plans routinely fail to pay for ER care, despite state and federal requirements to do so. Other states have received similar reports, and the California state Senate is considering a measure to toughen rules against this practice.

The industry has good reason to keep a close eye on emergency room use. Too many patients use the ER for basic health care when a much cheaper doctor's visit would suffice.

But what's needed to address that is better patient education about when ER visits are justified and better access to primary care for those who've long and had no choice other than the ER, not egregious denials for people with a good reason to seek emergency care.

Since the early 1990s, more than two dozen states have tried to staunch that practice with ''prudent layperson'' rules. The idea is that if a person has reason to think his condition requires immediate medical attention, health plans in the state are required to pay for the emergency care. Those same rules now apply for health plans contracting with Medicare and Medicaid.

A national prudent layperson law covering all health plans would help fill in the gaps left by this patchwork of state and federal rules.

At the very least, however, the industry should live up to its own advertised standards on payments for emergency care. Patients in distress should not have to worry about getting socked with big health bills by firms looking only at their own bottom line.

Mr. Speaker, there are few people in this country who have not personally had a difficult time getting health care from an HMO. Whether we are talking about cases like little Jimmy Adams or Jackie Lee or we are talking about people that we work with or even members of our family, the HMO industry has earned a reputation with the public that is so bad that only tobacco companies are held in lower esteem.

Let me give my colleagues a few statistics. By more than 2 to 1 Americans support more government regulation of HMOs. Last month the Harris poll revealed that only 34 percent of Americans think managed care companies do a good job of serving their customers. That is down significantly from 45 percent of a year ago, but 45 percent is certainly no statistic that I would be proud of if I were the HMO industry.

Even more amazing were the results when Americans were asked whether they trusted a company to do the right thing if they had a serious safety problem. Mr. Speaker, this is an amazing statistic. When Americans were asked whether they trusted HMOs to do the right thing if they had a serious problem, by 2 to 1 Americans would not trust HMOs in such a situation, and that level of confidence is far behind other industries such as hospitals, airlines, banks, even the automobile manufacturers.

In fact, about the only industry that fared worse than HMOs was the tobacco industry, and anyone who still needs proof about what the public thinks about it just needs to go to that movie ''As Good As It Gets.'' Audiences clapped and cheered, when I went and saw that movie with my wife, when Academy Award winner Helen Hunt expressed a strong expletive about the lack of care her asthmatic son was getting from their HMOs. And no doubt the audience's reaction was fueled by dozens of articles and stories very critical of managed care, bolstered by real-life experiences.

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

The New York Post, and I see my colleague from New York (Mrs. MCCARTHY) sitting here waiting, she knows the New York Post ran a series, a week-long series of articles on managed care, and some of the headlines were: ''HMO's 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 how about this one: ''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 bureaucrat reviewer told him to hold a fund-raiser. A fund-raiser? Mr. Speaker, I thought we were talking about patient protection legislation, not campaign finance reform.

□ 2145

To counteract this, some health plans have even taken to bashing their own colleagues. Here in Washington one ad declared, ''we do not put unreasonable restrictions on our doctors. We do not tell them that they cannot 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 plan cost controls are regulated by administrators but at PHN doctors are responsible for controlling costs.''

Mr. Speaker, advertisements like these demonstrate that even the HMOs know that there are more than a few rotten apples in the barrel. In trying to stave off Federal legislation to improve health care quality, many HMOs have insisted that the free market will help cure whatever ails managed care.

Mr. Speaker, I am a firm believer in benefits to a free market, but the health care market is anything but a free market. Free markets are not dominated by third parties paying first dollar coverage. Free markets do not reward customers for giving less service. Is there any other industry in this country that gets paid for doing less? And free markets do not feature limited competition, either geographically or because an employer says here is

your health plan, take it or leave it. Some choice a consumer has in that situation, and that is about the way it is for about 50 percent of the people in this country who get their insurance through their employers.

The Washington Business Group on Health recently released its fourth annual survey report on purchasing value in health care. Here are a few examples of how the market is working to improve quality care. Fifty-one percent of employers believe cost pressures are hurting quality. This is not employees. These are the employers. In evaluating and selecting health plans, 89 percent of employers considered cost. Less than half consider accreditation status and only 39 percent consider consumer satisfaction reports. Employees are given limited information about their plans. Only 23 percent of companies tell employees about appeals and grievance processes. In the last 3 years, the percentage of businesses giving employees consumer satisfaction results has dropped from 37 percent to 15 percent. So much for the quality aspect. Over half of employers offer employees an incentive to select plans with lower costs, but just 15 percent of plans offer financial inducements to their employees to purchase a higher quality plan.

Mr. Speaker, a recent Court of Appeals decision in the case Jones v. Kodak explains just how dangerous the ''free market'' is to patients. Mrs. Jones received health care through her employer Kodak. The plan denied her request for inpatient substance abuse treatment, finding she did not meet their protocols. The family took the case to an external reviewer, who agreed that Mrs. Jones did not meet the criteria for the benefits of the plan, but the reviewer observed, ''the criteria are too rigid and they do not allow for individualization of case management.'' In other words, the criteria were not appropriate.

In denying Mrs. Jones' claims, the Tenth Circuit Court of Appeals held that the Employee Retirement Income Security Act, ERISA, does not require plans to state the criteria used to determine when a service is medically necessary. On top of that, the Court ruled that unpublished criteria are a matter of plan design and structure, rather than implementation. Therefore, they are not reviewable by the judiciary.

Mr. Speaker, think about this for a minute. The implications of this decision, I think, are breathtaking. Jones v. Kodak provides a road map to health plans to deny any type of care they want. Under Jones v. Kodak, health plans do not need to disclose to potential or even to current enrollees the specific criteria they use 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.

Most important to the plans, the decision ensures HMOs that if they are following their own criteria then they are shielded from court review.

Mr. Speaker, this is why I so vigorously opposed the bill that passed this House last year because there was a provision in that bill that basically said the health plan can determine any definition of medical necessity that it wants. Because of this law that Congress passed 25 years ago, ERISA, the Employee Retirement Income Security Act, the courts are holding that they can do that, they can totally disregard generally accepted prevailing standards of medical care. They can have their own secret protocols.

As a reconstructive surgeon I have taken care of a lot of children with cleft lips and palates. In their own internal plan they can say, well, yes, we will cover cleft lip surgery but we are not going to allow it until the kid is 16 years old.

There would be nothing under current law that could prevent them from doing that. It is totally contrary to generally accepted principles of medical care. If you were the parents, think about this. Here your baby is born with a great big hole in the middle of his face, his lip is separated that far, he has a hole in the roof of his mouth, he can't speak, but according to these court cases on the interpretation of ERISA those health plans can do anything they want to and they do not even need to share the information with the beneficiaries.

Mr. Speaker, I have introduced legislation, H.R. 719, the Managed Care Reform Act, and it addresses these problems. It gives patients meaningful protections. It creates a strong and independent review process. It removes the shield of ERISA which health plans have used to prevent State court negligence actions.

It has received a lot of support, Mr. Speaker. It has been endorsed by consumer groups like the Center for Patient Advocacy, the American Cancer Society, the National Association of Children's Hospitals, the National Multiple Sclerosis Society. It has also been supported by many health care provider groups such as the American Academy of Family Physicians whose members are on the frontlines. They are the gatekeepers. They have seen how faceless HMO bureaucrats thousands of miles away, bureaucrats who have never examined a patient, denied needed medical care because it does not fit their plan ''criteria.''

I want to focus on one small aspect of my bill as it relates to liability. It has been a firm principle of this Republican Congress that people should be responsible for their actions. In the individual insurance market, if Blue Cross Blue Shield sells a plan to an individual and Blue Cross Blue Shield makes a medical decision that results in negligence, then they are liable. That is current law. That is the way it is in the States.

According to this law that Congress passed 25 years ago, if that plan is a self-insured plan they skate free. They do not have that responsibility. That is wrong. Congress created that loophole and Congress needs to fix it.

On the other hand, I do not want to see these cases simply end up ex post facto in the courts. It does not do Jimmy Adams any good. He cannot get his hands and his feet back after the fact.

So what do we need? We need to have an internal and an external appeals process so that those disputes are resolved before someone ends up with the injury.

I believe there is a reasonable compromise that should be supported on this issue, and it works like this and it is in my bill: If there is a dispute on a denial of coverage between the patient and his health plan, then go through an internal appeals process. If there is still a dispute, then either the patient or the health plan can take that dispute to an independent peer panel for a binding decision on the health plan.

There is another difference from last year's GOP bill. One could go to that independent review panel but it was not binding on the plan, their decision. So in the end the HMO could end up doing what they want. That should be changed. It should be binding on the plan and there should not be a conflict, any conflict of interest, between that independent review panel. So the benefit to the patient of that is that they get to have a second opinion that is free of any taint of conflict of interest on the part of either the doctor or the health plan.

The benefit to the plan is this, and when I talked about this with the CEO of my own Blue Cross Blue Shield plan in Iowa, he said, Greg, we are implementing the patient bill of rights. It is costing us almost nothing. We will see no premium increases from that. On that issue of liability, if there is a dispute on a denial of care, I could see going to an independent panel for an external review and I could see that panel determining medical necessity, and I could see it being binding on us, but if an independent panel has made that decision and it is binding on us, and we did not make that decision, i.e., the health plan did not make the decision, then we should be free of punitive damages liability. That is what I put into the bill.

So there is a carrot to the patient to get that second opinion but there is also on a dispute an incentive for the health plan to take it to that independent panel.

Let us say that a patient asks for apricot juice in order to treat cancer and the health plan very appropriately says, no scientific evidence for that, but that patient is still unhappy. The plan knows that they have an unhappy camper. In this situation, if my bill were law, the health plan could take that to the independent panel. They would know that they are going to get confirmation to support their decision, but in so doing they would also protect

themselves from any punitive damages liability. If they do not follow that independent panel's decision, then they are liable for punitive damages. I think that is the essence of the compromise that we should have on this bill.

In fact, this was recently written about in the Hartford Courant by an editorialist named John MacDonald, and I would insert his editorial in the CONGRESSIONAL RECORD at this point:

[From the Hartford Courant]

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 right 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 seven 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 is 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 a ''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.

I want to address a couple of issues before finishing. The first is the opponents to this legislation say this is going to be too costly, this legislation would cause premiums to just go up, skyrocket and then people would lose their insurance. That is not true.

Mr. Speaker, my bill will come in at a CBO estimate less than last year's patient bill of rights because I have removed some of the bureaucratic reporting requirements and also because of the punitive damages provision that I have in.

Even last year's patient bill of rights was scored by the Congressional Budget Office, as an estimate, for an increase of premiums of 4 percent over 10 years. That is significantly different from the advertising campaign that we are seeing around the country now where the HMO industry is saying 4 percent per year. Wrong.

Furthermore, Texas passed a bill, a strong patient bill of rights, that included a stronger liability law than in my bill.

The Scott and White Health Plan asked their actuaries how much should we increase our premiums because of that liability provision? The answer, 34 cents per member per month.

I would estimate that my bill will come in at a cost increase of somewhere around $3 per month for a family of four. That is about $36 a year for a family of four.

A survey by the National Federation of Independent Business, members of small businesses, employers, found that more than 95 percent of those employers would continue to cover their employees with health insurance even if the premiums increased by double that amount. We are talking about a small cost in order for people to be secure in knowing that the large amount of money that they are spending on their health care premiums, when they get sick, will actually mean something.

Mr. Speaker, we have talked about liability. We have talked about cost. Finally I want to say one thing about what my bill does not do. Recently I had a large employer from the upper Midwest come into my office and say we have businesses in every State. If your bill passes, then we would not be able to design a uniform medical benefits package for all of our companies' employees.

I was flabbergasted, Mr. Speaker. That is not what my bill does. ERISA will continue. I only change ERISA in terms of when a health plan makes a medical decision, in terms of their liability, but there is nothing in my bill that would say a multistate business would have to follow the State mandates of every State that it was in.

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They could continue, let me repeat, they could continue to design a uniform benefits package, and they would continue to be exempted from individual State benefit mandates.

Now, there are some who are looking at this legislation now and they want to add some untested and untried, and, in my opinion, some dangerous ideas to this legislation to try to kill the legislation. Some of these ideas are things like health marts. Health marts are sort of geographic association health plans. They are very similar to what Hillary proposed, Mrs. Clinton proposed in 1993, called HIPCS, Health Insurance Purchasing Coops. That was not an idea that I thought was appropriate at that time, and I do not think it is appropriate now, and I will tell my colleagues why.

Let me read from a letter to Congress from June 1997 by the American Academy of Actuaries. ''While the intent of the bill,'' and they are referring to the Republican bill, ''is to promote association health plans or health marts as a mechanism for improving small employers' access to affordable health care, it may succeed in doing so for employees with certain favorable risk characteristics. Furthermore, this bill contains features which may actually lead to higher insurance costs.''

The Academy went on to explain how those plans could undermine State insurance reforms. Quote: ''The resulting segmentation'' that would result from ideas such as an association health plan or a health mart, ''The resulting segmentation of the small employer group into higher and lower cost groups would be exactly the type of segmentation that many State reforms have been designed to avoid. In this way, exempting them from State mandates would defeat the public policy purposes intended by State legislatures.''

Those concerns have been echoed by the National Governors Association, the National Conference on State Legislatures, the National Association of

Insurance Commissioners. They argue that AHPs, and I might add health marts, quote, ''substitute critical State oversight with inadequate Federal standards to protect consumers and to prevent health plan fraud and abuse,'' unquote.

Mr. Speaker, on behalf of patients like Jimmy Adams who lost his hands and feet because an HMO would not let his parents take him to the nearest emergency room, I am going to continue to fight efforts to derail managed care reform by adding those sorts of untested and potentially harmful provisions to a clean managed care reform bill. I pledge to do whatever it takes to ensure that opponents of reform are not allowed to mingle those issues.

Do I think that we could do something on the tax side to help improve access to care? You betcha. We could make available tomorrow 100 percent deductibility for individuals to purchase their own health insurance, and we should. But, Mr. Speaker, adding these other issues into this mix, in my opinion, is a poison pill.

Now, recently I and the gentleman from Oklahoma, (Mr. COBURN) and the gentleman from Georgia (Mr. NORWOOD) have given to the chairman of my committee a draft, a consensus draft on patient protection legislation, and the American Medical Association has written me a letter that contains high praise for that draft. Mr. Speaker, I submit at this time full text of that letter:

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, May 12, 1999.

Hon. GREG GANSKE,
U.S. House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE GANSKE: On behalf of the 300,000 physician and student members of the American Medical Association (AMA), I would like to thank you for your efforts in drafting a compromise patient protection package for the Commerce Committee. The draft proposal, developed by Representatives Tom Coburn, MD (OK) and Charles Norwood, DDS (GA), and you, is a significant milestone in the advancement of real patient protections through the Congress. We look forward to working with you to perfect the draft bill through the committee process and to pass a comprehensive, bipartisan patient protection bill this year.

It is imperative that a patient protection bill be reported out of committee and be considered on the floor prior to the July 4th recess. The AMA stands ready to help further advance these important patient protections through the committee process, the House floor and final passage.

The AMA applauds the inclusion of ''medical necessity'' language that is fair to patients, plans and physicians alike. We are particularly pleased with the non-binding list of medical necessity considerations that you have incorporated into the draft bill.

The AMA is pleased with the incorporation of the ''state flexibility'' provisions that allow patient protections passed by various states to remain in force. Allowing preexisting patient protection laws to remain in force is critical to the success of federal patient protection legislation such as the draft bill.

The draft bill also offers patients a real choice by incorporating a ''point of service'' option provision. The AMA supports this important patient protection because it puts the full power of the free market to work to protect consumers.

We applaud your inclusion of a comprehensive disclosure provision that allows consumers to make educated decisions as they comparison shop for health care coverage. The AMA also notes with great appreciation the many improvements that the draft bill makes over last year's Patient Protection Act.

The draft bill expands consumer protections with a perfected ''emergency services'' provision. By eliminating the cost differential between network and out-of-network emergency rooms, the draft bill offers expanded protection for patients who are at their most vulnerable moments.

We support the strides the draft bill takes in protecting consumers with a comprehensive ban on gag practices. This is an important consumer protection that the AMA has been seeking for more than six years.

We commend the improvements incorporated in the ''appeals process'' provisions of the draft bill. The bill represents a major step toward guaranteeing consumers the right to a truly independent, binding and fair review of health care decisions made by their HMO.

The April 22nd draft copy of the bill makes a strong beginning for the Commerce Committee and the 106th Congress on the issue of patient protection and reaffirms the leadership role that you have assumed in the process. While you have raised some concerns about the process, the AMA stands ready to assist in completion of this legislative task. The AMA wishes to thank you for your efforts and work with you and the minority to pass a comprehensive, bipartisan patient protection bill this year. We look forward to working with you toward this goal.

Respectfully,
E. RATCLIFFE ANDERSON, JR., MD.

Mr. GANSKE. I sincerely hope, Mr. Speaker, that the chairmen of these committees of jurisdiction will not substantively change that draft and that they will keep it clean. We need to move this issue in a reasonable time frame. A strong patient protection bill should be debated under a fair rule on the floor soon; not in the fall, but in the next few months. There are an awful lot of people, our constituents out there, who today are being harmed by managed care decisions.

Mr. Speaker, we need to fix this now, and I look forward to working with all of my colleagues to see that real HMO reform is signed into law this Congress.

HEALTH CARE REFORM AND NATIONAL DRUG CONTROL STRATEGY AND POLICY

The SPEAKER pro tempore (Mr. SHIMKUS). Under the Speaker's announced policy of January 6, 1999, the gentleman from Florida (Mr. MICA) is recognized for the remainder of the Majority Leader's hour of approximately 23 minutes.

Mr. MICA. Mr. Speaker, I first want to comment and compliment my colleague, the gentleman from Florida (Mr. GANSKE) on his Special Order and on his proposal to deal with some of the problems we have seen relating to HMOs and health care. I do want to comment, before I get into my Special Order on the topic of illegal narcotics, about what the previous speaker has been discussing, and he did bring up towards the end some of the proposals relating to the Patients' Bill of Rights.

I would like to pass on to the Speaker and my colleagues this information: In the previous Congress I had the opportunity, actually for 4 years, to chair the House Subcommittee on Civil Service. In that capacity I oversaw the largest health care plan in the country, which is made up of almost 2 million Federal employees and 2.2 million Federal retirees and some 4 million to 5 million additional dependents; about 9 million people participating in the Federal Employees Health Benefit Program. Part of my responsibilities of chair of that subcommittee was to look at that program, and I remember several years ago when President Clinton proposed a Patients' Bill of Rights to the Congress to be passed to resolve, he said, the issues and problems we have with HMOs, and it was going to be his saving grace for these programs.

Well, we conducted a hearing, and I will never forget that hearing. We had the administration officials in, OPM officials in, and we asked about the President's proposed Patients' Bill of Rights. To a single individual who testified, every single individual who testified said that there was no medical benefit for the proposals under the President's Patients' Bill of Rights, but there was more reporting, more mandates, more requirements, and they possibly predicted more costs. That was several years ago when he proposed that to our subcommittee, the Subcommittee on Civil Service.

Now, he could not pass his so-called Patients' Bill of Rights, and it sounds great, through the Congress. So what he did, and a lot of people did not pay attention to it but we did on the Civil Service Subcommittee, he submitted another one of his fiats. By Executive Order he imposed his Patients' Bill of Rights where he could, and that is on our Federal employees' HMO plans.

Well, lo and behold, before I left that chairmanship, I conducted another hearing just at the end of last fall, and one of the purposes of that hearing was to see what had happened with the imposition of the President's Patients' Bill of Rights on the Federal employees' health care plan. Well, my goodness. We experienced over a 10 percent, on average, increase in premiums, not entirely all due to the President's Patients' Bill of Rights; prescription drugs, I must say, were part of that, but there were very substantial costs that were passed on, and they contributed to almost a record increase in employee health costs. While the rest of the industry was experiencing a 2.6 to 3 percent increase, our Federal employees, Members of Congress too, were getting a 10 percent-plus, on average, increase in their premiums.

One of the things that has made our Federal Employees' Health Benefits Program so good is we have had over 350 different vendors providing a package. We sat and developed a package of