tried to do more to keep drugs from coming into the United States.''

Mr. Speaker, the President says one thing. The facts prove something totally different. It is sad that after years and years of deadly silence, we finally have the President come out in one of the rare occasions he ever mentions illegal narcotics and says two things that do not gibe in any fashion with the facts as to what actually took place.

It is very sad that I report this to the House, but I think that the facts relating to this important problem that is facing our Nation that has condemned so many families tragically to losing loved ones, 14,000 people died last year alone because of direct results of illegal narcotics. It is very sad, indeed, that the President of the United States paints a picture that does not gibe with the facts.

MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. VITTER). Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 27 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, in just 3 days, this House will adjourn without having brought to the floor the Patients' Bill of Rights, the Democrats' legislation for comprehensive HMO reform.

I bemoan the fact that that is the case. I think that this legislation and the need to address the issue of HMO reform is really the preeminent issue that needs to be addressed in this House, in this Congress, in this session of Congress.

I have to say that the Republican leadership since the beginning of the year has made many promises with regard to the Patients' Bill of Rights and the whole issue of HMO reform. First, the Speaker said that we would follow the normal committee process and an HMO reform bill would have hearings in the relevant committees and have a markup in committee and come to the floor in the normal way, but that has not happened.

Then, as Members know, in the other body basically the Democrats forced the issue, forced the other body to bring up HMO reform. Unfortunately, the bill that was finally passed was not real reform, was ineffective, was a sham, but the impetus, if you will, that at least some sort of HMO reform would be brought up in the Senate caused the Speaker and the Republican leadership just a few weeks ago after the Senate took action and had a hearing and had a markup on the floor, basically forced the Speaker to say that a bill would come to the floor, an HMO reform bill would come to the floor in the House of Representatives sometime before the August recess.

Well, Mr. Speaker, the August recess begins probably this Friday and Democrats have basically been pushing to achieve action here on the floor for the Patients' Bill of Rights, our Democratic HMO reform. We actually had Members come to the floor over here in the well and sign a discharge petition that would force the Republican leadership to bring up our Patients' Bill of Rights. One hundred eighty-three Members signed that discharge petition. But now ultimately to no avail. The Speaker, the Republican Speaker, just announced that no action will be taken on the bill before the August recess.

I ask why? The answer, I think, is very simple. That is, because the Republican leadership here in the House as well as in the Senate is a captive of the insurance industry. The insurance industry does not want a true HMO reform, a true comprehensive bill to come to the floor of the House because, unlike the other body, they realize that if it does, it will pass. Some of my colleagues, a handful of my colleagues on the other side who are health care professionals, doctors, dentists, have made the point that they will vote for a strong HMO reform bill, something akin to the Democrats' Patients' Bill of Rights. When they made that statement and basically indicated to the Republican leadership that they would join with the Democrats in passing a bill, well, all of a sudden this week we find that the Speaker and the Republican leadership say, ''No, no, we're not going to bring a bill to the floor. We can wait until the fall. We'll have further discussions. No action will be taken now.''

I just want to commend the Republicans on the other side of the aisle, those few, all of whom, I think, who have been most outspoken are health care professionals, doctors, because they have stood up and said that we need a strong HMO reform bill and they refuse to say that the action taken by the other body meets that need. In fact, it does not meet that need.

Mr. Speaker, if I could, I hope that during the August break and when we come back in September that we will see a bipartisan coalition of the Democrats, all of whom support the Patients' Bill of Rights, and enough Republicans on the other side that will come together in a bipartisan way to demand action on something like the Patients' Bill of Rights so we can have true comprehensive HMO reform come to the floor when we return in September.

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Mr. Speaker, if the House leadership is not willing to bring it up, I think we will simply have to get every Democrat to sign the discharge petition and join with some of the Republicans who are willing to sign it to force the issue to make sure that the Patients' Bill of Rights or some strong comprehensive reform like it comes to the floor.

As my colleagues know, Mr. Speaker, I just wanted to point out that increasingly we are seeing every comprehensive report, every study that is being done around the country about what the American people want, what the health professionals want, what people see basically as common sense reform with regard to HMOs, that we need some kind of action taken.

There were two reports that came out just in the last week that I wanted to mention tonight. One of them was basically a report, if you will, where various doctors and health care professionals were interviewed. It was a survey that found nearly nine in 10 doctors and more than one in four consumers are having trouble receiving the medical care and services they need within the context of HMOs managed care, and as a result between one-third and two-thirds of the doctors said the service denial resulted in adverse health consequences for the patient.

The types of problems that we are seeing that myself and others have documented on the floor about people who have had abusive situations with managed care and with HMOs, this is becoming commonplace, and both consumers, patients as well as doctors, are decrying the situation, and I say to my colleagues and, I guess, to the American people as well, why is it that the Republican leadership will not allow us to take action when the majority of us in a bipartisan way would like to see comprehensive HMO reform? And it always comes back to the same thing, and that is the money spent by the insurance industry against this type of comprehensive HMO reform.

The second survey that came out in the last week or so basically said that last year 1.4 to $2 billion was paid to lobbyists to influence politicians and policy, a 13 percent increase from 1997; and for the second year in a row the insurance industry topped the list in lobbying costs, nearly $203 million last year alone.

The Republicans basically on the leadership or amongst the Republican leadership are bowing to the insurance industry which is spending millions of dollars once again trying to defeat true HMO reform.

Mr. Speaker, I just wanted to, if I could, make reference to a New York Times editorial that was in the New York Times on July 16 of this year, and it just kind of sums up what is happening out there and why we cannot see action on the House floor, and I quote. It says:

''There is no mystery here. Campaign money is dictating medical policy in the Senate. The political system and especially the Republican party is awash in money from the health care industry. As President Clinton said yesterday, and this was back on July 16, GOP senators could not support the Patients' Bill of Rights because the health insurers will not let them do so. That is the bottom line, Mr. Speaker.''

Mr. Speaker, if I could just use a couple minutes of my time to talk about some of the comparisons between the

Patients' Bill of Rights, the bill that the Democrats and some of the Republicans want to bring to the floor, versus the bill that passed the Senate and the one that would have been considered, I believe, on the floor pursuant to the Republican leadership if they thought that they could get the votes to pass it. There is a real contrast, if you will, between that Republican Senate bill and the Democratic Patients' Bill of Rights, and let me just go through a few highlights of it, if I could this evening.

The Republican bill, and I refer to the Senate bill, leaves more than 100 million Americans uncovered because most substantive protections in the bill apply only to individuals enrolled in private, employer-based, self-funded insurance plans, and self-funded coverage is typically offered only by large companies. Only 48 million people are enrolled in such plans, and of those 48 million only a small number, at most 10 percent, are in HMOs.

So the Senate Republican bill really does not help effectively anyone, does not provide patient protections really to almost anyone.

What the Democrats insist on in the Patients' Bill of Rights and the Republicans that support us have said is that all, all 161 million privately insured Americans have to be covered by the bill, by the patient protections.

Let me just give my colleagues some of the other examples that I think are important. In the Democratic bill we have talked about the prudent lay-person standard in the situation where you go to an emergency room. This is so important. So many people come up to me and say, if I have under my HMO, if I want to go to the local emergency room, I cannot. I have to go to one maybe 20 miles away, 30 miles away, 50 miles away, and when a person is in extremis or has a problem and has to go to an emergency room, they do not want to have to travel 20 or 30 miles away when the emergency room for the local hospital is maybe only within a mile distance from where they are.

Well, under the Democratic bill, what we say is that an individual who has symptoms that meet a prudent lay person, what the average person would think is the need to go to the emergency room under given certain circumstances, that that standard should allow them to go to the local emergency room, the closest one, without pre-authorization, and the insurance plan must cover the visit. The plan may not impose additional charges for use of non-network facilities.

It is unclear in the Republican Senate bill whether that kind of standard would apply. There really is not any prudent lay person standard, if you will, in the Republican bill.

Most important in the Democratic bill is that we provide for adequate specialty care. It provides the right in our Patients' Bill of Rights to specialty care if specialty care is medically indicated. It ensures no extra charge for use of non-network specialists if the HMO has no specialist in the network that is appropriate to treat the condition.

I just wanted to mention a couple other things that I think that are really crucial in terms of the differences between the Democratic bill and what the Republicans passed in the Senate, and one of those most important distinctions is on the issue of medical necessity. The issue of medical necessity is basically whether or not a particular type of care, operation, equipment, length of stay in the hospital will be provided in a given circumstance if you get sick, and basically the Republican Senate bill allows HMOs to define what is medically necessary. No matter how narrow or unfair to patients, the HMO's definition is their definition controls in any coverage situation including decisions by an independent third-party reviewer.

The Democratic bill by contrast codifies a traditional definition of medically necessary or appropriate means of service or benefit consistent with generally accepted principles of professional medical practice. In other words, what we are saying in the Patients' Bill of Rights is that the doctor and the patient have to decide based on standards that are used for most physicians in a given circumstance. It is an independent standard, if you will, not defined by the HMO.

Most important also, the distinction on the issue of external appeals. The Republican Senate bill allows the HMO to choose and pay the appeal entity that decides the case. It also allows the HMO or insured to define medical necessity, tying the hands of the independent review entity and forcing them to defer to the HMO's definition. It does not provide, the Republican bill, an appeal when most rights under the bill are denied. For example, when emergency care is denied or access to a specialist is denied, no appeal is allowed.

The Democratic Patients' Bill of Rights by contrast ensures the State or Federal agency controls the process for choosing the independent appeal entity, not the insurer.

□ 2320

It ensures a de novo review, a fresh look at the facts. It ensures the reviewer's decision is based on a statutory definition of medical necessity, not the insurer's plan's definition, and the review of best available medical evidence, and all denials of care are appealable.

Finally, the most important distinction between the Democratic Patients' Bill of Rights and the Republican Senate bill is the ability to hold HMOs accountable. Under the Republican bill, it maintains existing Federal law that basically preempts state remedies, and the only remedy under ERISA, which is the federally covered plans, is recovery of the cost of the denied benefit.

For example, if a patient is denied a mammogram and dies of breast cancer as a result, the only remedy under the Republican bill available to the family is the recovery of the costs of the mammogram, not the damages that result, including the death of the patient.

Under the Democratic bill, by contrast, the ERISA presumption of State remedies, the ability to go to State court, only exists when the actions of an HMO have killed—well, essentially what we are saying is that that ERISA preemption is repealed, and you can go to State court and you can seek damages and you can recover for the damage that the HMO has inflicted, just like you would in any normal tort action.

Mr. Speaker, I think that there are crucial differences here, and I think that ultimately what it comes down to is money. It is a very sad day, but what we are seeing is the insurers increasingly spending a lot of money on TV trying to get the word out that somehow what we are trying to do with the Patients' Bill of Rights is not going to work, that it is going to cost more money, that it is not going to achieve the desired result.

The fact of the matter is that the American people are crying out for comprehensive HMO reform. They want to see something like the Patients' Bill of Rights passed. Again, I want to commend some of my Republican colleagues, particularly the physicians on the other side of the aisle who are saying, you know, we are practicing doctors. We see what happens. We know there are abuses, and we want strong HMO reform passed, something like the Democratic bill, and we will work together with the Democrats to achieve a bipartisan proposal.

If I could just conclude tonight, I always like to talk when I come to the floor about local people in my part of New Jersey who have had problems with HMOs, because that is really what it is all about. We are talking a little bit in the abstract here about what needs to be done, but the bottom line is it is our own constituents coming to us and saying we need HMO reform, we need something done because of what is happening to them.

If I could just conclude tonight with a letter that was in the Asbury Park press, which is the largest circulation daily in my district in Monmouth County, New Jersey, and this was in the Asbury Park Press, a letter to the editor on Thursday, July 15, from Jack Moriarty of Dover Township. I am going to read part of it because I think it is so telling.

He says,

Each time I must deal with my health maintenance organization on any matter other than the routine and the basic, problems continue. This is a system designed and managed to restrict our access to medical care and to place roadblock after roadblock in our way as we attempt to circumvent that design feature.

On July 6th I sustained an eye injury while swimming when a thumb with sharpened fingernail found its way into my eye. I stopped

the bleeding, applied ice and went to bed. This morning there was blood on the pillowcase, the pain had intensified, and my vision was blurred. I reasoned this required an objective medical evaluation to ensure there was no permanent damage. Thus began my hassle for the day.

What followed was more than a dozen telephone calls to various medical professionals and administrators to get permission to go to the doctor and secure the required referral for them to be paid. I knew what had to be done, but what is the justification for wasting my time and causing me anxiety and aggravation? As a professional, if I am not working, I am not being paid. Consequently, the very real financial loss I endure by sitting in a waiting room makes me choose the medical visit option only as a last resort.

That day I wasted additional time and resources playing phone tag all around the State trying to get some paperwork-pushing clerk to give me permission to do what I knew to be right. And, by the way, we pay for this, which is what truly amazes me.

What should we do? I suggest we all write to our State and Federal elected officials demanding that they return the right of self-determination in health matters to us by passing the Patients' Bill of Rights and similar state statutes. It is no wonder the doctors are unionizing. Perhaps the patients should too.

He was talking about an eye injury, but we just know that with the case of eye injury or so many other serious problems that people face the same reality.

All I am really saying tonight, Mr. Speaker, because this may be the last opportunity we get to talk about this before the August break, is let us bring up the Patients' Bill of Rights. Let us bring up HMO reform. Let those Democrats and those Republicans, and I see my colleague is going to come after me, the gentleman from Iowa (Mr. GANSKE), let us put together a bill I think that is very close to the Patients' Bill of Rights that really provides comprehensive HMO reform. This is what the public wants, this is what we keep hearing every day from our constituents, and I know that I am going to use the time during this August break to go out and explain to the public why we need to bring this up on the floor of the House when we come back in September.

I am confident when I see people like my colleague, the gentleman from Iowa (Mr. GANSKE) and others on the Republican side that are demanding that we take action, that when we come back in September, either through the means of a discharge petition or because the Republican leadership finally sees they have to do something, that we will see comprehensive HMO reform. But I am not going to rest, and I know the gentleman from Iowa (Mr. GANSKE) and a lot of us are not going to rest until that happens.

MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. VITTER). Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for 34 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, here it is, about 11:30 p.m. in Washington, and our families will be happy to know that we are here on the floor, taking care of the country's business. I wish to speak for the remainder of this evening about managed care reform. One of these days we are going to pass this, and my friend from New Jersey and I will maybe have to stop passing like ships in the middle of the night, coming to the floor to speak about this issue.

But, Mr. Speaker, it has become I think commonplace knowledge that we have problems with managed care in this country. That is recognized by a lot of the humor that we see in the country.

Several years ago, a joke started going around the country about the three doctors who died and went to heaven. The first doctor was a neurosurgeon. St. Peter asked him, ''What did you do for a living?'' He said, ''I took care of victims of automobile crashes who had injured their heads and tried to get them back to a normal life.'' St. Peter said, ''Enter, my son, and enjoy heaven.''

The next doctor who came up to the pearly gates was asked by St. Peter what he did. He said, ''I was a heart surgeon and I took care of people who were having heart attacks and managed to prolong their lives so that they could spend them with their families.'' St. Peter said, ''Enter, my daughter, and enjoy heaven.''

The third doctor who came up to the Pearly Gates was asked by St. Peter, ''What did you do?'' He said, ''Well, I was an HMO manager.'' St. Peter kind of stroked his beard and he said, ''Son, you may enter, but only for 3 days.''

Now, everyone has heard that joke. Why is that funny? Well, number one, because there is a kernel of truth in it and there is a twist. All of us who have had to deal with managed care, and as a physician I certainly have in advocating for my patients, knows that managed care has put severe time limits on whether patients can stay in the hospital. We will talk about some of those examples.

So now it is sort of funny that this HMO manager is going to get his comeuppance. I think that is part of the humor.

The humor of HMOs, in order for something to be humorous, people have to understand the underlying point. So let us just look, for example, at some of the cartoons that we have seen around the country.

Here is one. We see a doctor sitting at a desk. He is reading a paper. Behind him is an eye chart that says ''enough is enough,'' and the doctor is saying, ''Your best option is cremation, $359 fully covered.'' The patient, sort of nonplussed, is sitting there saying, ''This is one of those HMO gag rules, isn't it doctor?''

Now, this is a little harder to see for my colleagues here in the audience tonight. I will have to read this to you. Here is a physician sitting behind his desk. He is talking to a patient. The physician is saying, ''I will have to check my contract before I answer that question.''

Now, what is the point of this cartoon? Well, about 3 years ago it became known that HMOs were writing contracts that required the doctor to check with the HMO before they told the patient all their treatment options. Now, think about that.

☐ 2330

Let us say that one is a woman, one has a lump in one's breast, one goes in to see one's doctor. One's doctor takes one's history, does one's physical exam, and then says, ah-hah, excuse me, and steps outside, gets on the phone to the HMO and says, ''Mrs. So-and-so has a lump in her breast. She has got three treatment options. One is more expensive than the other. Is it okay if I tell her what her three options are?''

I mean, that is awful. As a practicing physician in solo practice for 10 years after medical school and residency, I can tell my colleagues, that the doctor-patient relationship will not stand that type of restriction on communication.

Patients have to trust their physician to be able to tell them the whole story. It may be that the HMO is not going to cover part of the treatment or one of the options, but the patient has every right to know what all the options are at a minimum.

Then we start to get into some things that are a little less than funny on an issue like this. Here is a headline from the New York Post: ''What his parents did not know about HMOs may have killed this baby.'' Now, here is an infant that died possibly because his HMO prevented his physician from communicating to his parents the entire story. It is not so funny anymore.

Let us go to the case of a lady whose story was covered in Time Magazine a couple years ago, well documented. This lady is no longer alive. Her HMO made a medical decision to try to limit her and her family, her husband, from knowing all of her treatment options. They put a lot of pressure on the medical center to prevent and actually change their opinion on what kind of treatment this patient should have.

This lady could be alive today as a mother to her children and a wife to her husband had not that HMO made a medical decision that limited the information that she got. Not so funny anymore.

So what happened? Well, I and the gentleman from Massachusetts (Mr. MARKEY) in a bipartisan fashion reached across the aisle, and we got about 285 co-sponsors to sign a bill called the Patient Right To Know Act. This was about 3 years ago now, 285 bipartisan co-sponsors.

We discussed some suspension bills here tonight. Just with the cosponsors alone, we could have brought that to the floor and passed it under suspension. Not to be. I could not get my