Mr. HULSHOF. My colleague is absolutely right, and I thank him for those remarks, and I am sure the people of New Jersey appreciate it.

Our hearts do go out to victims in other States. New Jersey has been hard hit. Many States in the East have been hard hit. As the flood waters receded across New Jersey, the death toll from Hurricane Floyd increased in our State. Surging flood waters caused hundreds of millions of dollars of damage and claimed four lives.

As officials struggled to cope with the thousands of refugees and families left to deal with contaminated drinking water and total devastation, in many cases, of their homes, we also have to deal with highway closures and lingering phone and power outages, which interfere with the ability to deal with the problems that families face.

Eight of the counties hardest hit by Floyd have been declared federal disaster areas, including three counties in my district in Central New Jersey, including Middlesex, Mercer, and Somerset Counties. In a number of places the flooding exceeded the boundaries of the hundred-year flood.

Over the past few days, I have seen firsthand the damage that the hurricane has caused. In Lambertville, for example, I toured the middle school, where water had flowed through the school. Mud covered the floors. There were floating school supplies and overturned and floating desks through the building. Officials there told me they expect the cleanup effort to cost up to $1.5 million just in that one school.

In Branchburg, I have watched as families shoveled mud from their living areas, their shops, their basements, their belongings ruined, and homes permanently damaged. There was water everywhere but none to drink, as flooding contaminated drinking water sources. Still many people are without drinking water. They are advised to boil water. More than 200,000 residents in my district were found without water.

The scenes of devastation, however, did bring forth tails of heroic rescues. Many men and women devoted many exhausting hours to the rescue efforts, and they are to be commended. In this time of devastation, it gives us some comfort to think of the men and women of New Jersey who thought first of their neighbors. This inextinguishable spirit of the citizens of New Jersey has burned brightly in the days of this disaster, and it will continue to burn brightly. But that will not restore the damage caused by Hurricane Floyd.

There will be time in the coming weeks to talk about lessons learned from the flooding, and there are lessons to be drawn from this, lessons about the effect of loss of open space on flooding. But for now our attention goes to assisting the victims of the flood and to extolling the work of the rescue and repair efforts of those involved in those efforts.

While the federal disaster declaration is a substantial step forward in helping central New Jersians start to put their lives back together, more assistance is necessary. I urge my colleagues to join me in supporting a legislative package to provide relief to the citizens that have been hurt and whose lives have been turned upside down by Hurricane Floyd.

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. Well, Mr. Speaker, it is a sobering time to be here on the floor and to listen to my colleagues describe the natural disaster that has occurred all along the East Coast from Hurricane Floyd. On behalf of the people of Iowa that I represent, and the entire State of Iowa, we extend our condolences and our sympathies.

We remember very well 6 years ago when we had the floods of the century in our State. I represent Des Moines, Iowa, and we were without water, drinkable water for over 3 weeks. So we understand the problems that people are having, and our hearts go out to the families of people who were lost in this terrible storm.

My State received a lot of help from States around the country, including those on the East Coast. I am sure that we have plans to reciprocate that generosity, and we certainly received our share of federal help in terms of FEMA disaster aid when we had our floods, and I will certainly support helping our neighbors on the East Coast with their terrible problems as well.

Mr. Speaker, I want to speak a little bit about managed care reform tonight. I was very pleased when on this Friday past the Speaker of the House, the gentleman from Illinois (Mr. HASTERT), said that we will have a debate here in the House of Representatives the week of October 3. I would say that it is about time.

We had a very abbreviated debate last year on patient protection legislation. Really only had about an hour of debate on each of the bills. It was not a debate that did this House a lot of credit, and I hope that the debate we will have in 2 weeks will be a much better one and a fair one as well.

I do not expect that it will be easy for those of us who want to see comprehensive managed care reform pass the House. I suspect we will see a lot of amendments. There will be a lot of debate on alternatives. But I firmly believe that a vast majority of the Members of the House of Representatives want to pass a strong patient protection piece of legislation.

We watched the debate that occurred in the other House a few months ago, and a large number of us were very disappointed that the other House did not pass a more substantive bill. We are going to get our chance here in the next couple of weeks.

Why is this important? Well, for months I have been coming to the floor at least once a week to talk about the need for managed care reform. I have talked about a lot of different cases. And as I think about the people that have appeared before my committee, the Committee on Commerce, or that have appeared before other committees, victims of managed care abuses, I think about a family from California, where a father and his children came. Their mother was not with them because she had been denied treatment by her HMO, and it had cost her her life.

I think about a young woman who fell off a cliff, just 60 or so miles from Washington. She lay at the foot of that cliff with a broken skull, broken arm, and broken pelvis. She was air-flighted to a hospital, and then the HMO denied payment because she had not phoned for prior authorization.

I think about a young mother who was taking care of her little infant, a 6-month-old boy, who had a temperature of 104 or 105. And she did all the things she was supposed to with her HMO. She phoned the HMO. And the HMO spokesperson said, well, we will authorize you to take little Jimmy to an emergency room, but the only one we are going to authorize is 60, 70 miles away.

So little Jimmy's mother and father were driving him to a hospital. They had only been authorized to go to one hospital. They had to pass three other hospital emergency rooms enroute, and then he had a cardiac arrest and his mother tried to keep him alive as his dad was driving frantically to the emergency room.

They got him to the emergency room and a nurse runs out, and the mother leaps out of the car with her little baby and screams, Help me, help me. The nurse starts mouth-to-mouth resuscitation, and they put in the IVs and they start the medicines. They managed to save his life. But because of that HMOs decision, they were not able to save all of him. He ended up with gangrene of his hands and his feet and they had to be amputated. All because of that decision that that HMO made that prevented them from going to the nearest emergency room.

My colleagues, under federal law, that health plan which made that medical decision is responsible for nothing other than the cost of his amputations.

Yes, Mr. Speaker, I remember a lot of people who came before our committee and other committees. I remember a young woman who, with her husband sitting next to her, broke down in tears in describing how when, she had been pregnant, towards the end of her pregnancy, and she had a high-risk pregnancy, her doctor said that she needed to be in the hospital so that they could monitor her little baby, who was yet unborn. And the HMO said, Oh no, no, that is not medically necessary. You don't need that. We are not going to pay for it. You go on home. You go home, and we will get you a nurse to

sit with you part of the day. And at a time when the nurse was not there, the baby went into fetal distress and died.

And I can remember Florence Corcoran crying before our committee. But, Mr. Speaker, under federal law, that HMO which made that decision on medical necessity, they are liable for nothing.

There are lots of reasons and lots of people that have come before us, before Congress, in the last few years that have pointed out the need to do some real managed care reform. I remember one lady in particular who appeared before our committee. Her name was Linda Peeno. She was a claims reviewer for several health care plans, and she told of the choices that plans are making every day when they determine the medical necessity of treatment. I am going to tell my colleagues her story.

She started out by saying, I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken before 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 in my job and contributed to my advancement afterwards. Not only did I demonstrate I could do what was expected of me, I exemplified the ''good company'' employee. I saved a half a million dollars.

Well, Mr. Speaker, her anguish over harming patients as a managed care reviewer had caused this woman to come forth and bear her soul in a tearful and husky-voiced account. And the audience, I remember very well, Mr. Speaker, the audience started to shift uncomfortably, because there were a lot of representatives from the managed care industry sitting there listening. And the audience grew very quiet. And the industry representatives averted their eyes. And she continued.

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She said,

> 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 of healing his or her fellow human beings. The primary ethical norm is ''do no harm.'' I did worse, she said, I caused death.

She went on, she said,

> Instead of using a clumsy bloody weapon, I used the simplest, cheapest 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.

She was like that voice at the other end of the line of that young mother phoning about her child. ''Like a skilled soldier,'' she said,

> I was trained for this moment. When any moral qualms arose, I was to remember I was not denying care; I was only denying payment.

Well, Mr. Speaker, I put this proviso in that. For the vast majority of these people, when an HMO denies payment, that is a denial of care because most people cannot afford the care if their insurance company denies it.

She went on.

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

At that point, Ms. Peeno described many ways managed care plans deny care. But she emphasized one in particular, Mr. Speaker, and that is going to be an issue that is going to be debated here in about 2 weeks; and that issue is one of the crucial issues of managed care reform, and that is the right to decide what care is medically necessary.

Under Federal law, employer plans can decide what is medically necessary. This is what Ms. Peeno had to say about that.

> There is one last activity that I think deserves a special place on this list, and this is what I call the smart bomb of cost containment, and that is medical necessities 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 are rarely available for prior review by the physicians or the members of the plan.

Then she closed with this statement that brought chills to a lot of people's spines because she invoked something that happened about 50 years ago. She said,

> We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry.

Well, Mr. Speaker, I have spoken many times on this floor about how important it is for patients to have care that fits what we would call ''prevailing standards of medical care.'' Let me give my colleagues one example.

One particularly aggressive HMO defines ''medical necessity'' as the ''cheapest, least expensive care.''

So what is wrong with that, my colleagues say? Well, before I came to Congress, I was a reconstructive surgeon and I took care of a lot of children born with birth defects, like cleft lips, cleft palates. A cleft palate is a hole that goes right down the roof of the mouth. The child is born with this defect. They cannot eat properly. Food comes out their nose. They cannot speak properly because the roof of their mouth is not together.

The standard treatment for that, the prevailing standard of care, is a surgical repair. But under this HMO's definition of ''medical necessity,'' they say the cheapest, least expensive care is what we define as ''medically necessary.''

Do my colleagues know what that could mean? That could mean that they could say, hey, this kid does not get an operation. We are just going to provide him with a little piece of plastic to shove up into that hole in the roof of his mouth. After all, that will kind of help keep the food from going up into his nose.

Of course he will not be able to learn to speak properly. It would be a piece of plastic like an upper denture, and that certainly would be cheaper than a surgical repair. But I tell me colleagues what, Mr. Speaker, that does not speak much to quality.

Well, on this floor in a couple of weeks we are going to see a bill introduced by my colleague and friend, the gentleman from Ohio (Mr. BOEHNER) from Ohio, and I guarantee my colleagues that it will have in it a definition of ''medical necessity'' that will allow an HMO to continue to define ''medical necessity'' in any way that it wants to.

I would advise my colleagues to maybe talk to the mother of this little boy who no longer has any hands or feet about definitions of ''medical necessity'' or speak to this family from California whose mother is no longer alive because the plan arbitrarily defined ''medical necessity'' in a way that did not fit prevailing standards of care. Or maybe they ought to speak to Florence Corcoran about how now she does not have a beautiful, little baby because of a decision that her HMO made on ''medical necessity.''

Mr. Speaker, common sense proposals to regulate managed care plans do not constitute a rejection of the market model of health care. In fact, they are just as likely to have the opposite effects. I think if we pass strong, comprehensive, common sense managed care reform that we will be preserving the market model because we will be saving it from its most destructive tendencies.

Surveys show that there is a significant public concern about the quality of HMO care; and if these concerns are not addressed, Mr. Speaker, I think it is likely that the public will ultimately reject the market model. But if we can enact true managed care reform, such as embodied in the Norwood-Dingell-Ganske-Berry bill, then consumer rejection of the market model is less likely.

Mr. Speaker, this is not a novel situation. Congress has stepped in many times in the past to correct abuses in industries. That is why we have child labor laws and food and drug safety laws. That is why Teddy Roosevelt broke up the trusts. Those laws, in my opinion, help preserve a free enterprise system. And Congress would not be dealing with this issue were it not for past Federal law.

For a long time Congress had left health insurance regulation to the States; and, by and large, they have done a good job. But Congress passed a law called the Employee Retirement Income Security Act some 25 years ago in order to simplify pension management and, almost as an afterthought, employer health plans were included in the exemption from State law. Unfortunately, nothing was substituted for

effective oversight in terms of quality, marketing, or other functions that State insurance commissioners or legislatures have effectively done. That that lack of oversight, coupled with lack of responsibility for the medical decisions that they make, has resulted in the abuses for people like little Jimmy Adams or Florence Corcoran or a number of others.

Under current Federal ERISA law, if they receive their insurance from their employer and they have a tragedy, like their little boy loses his hands and feet because of an HMO decision, their health plan, their HMO, is liable for nothing, nothing, other than the care of cost of the treatment, i.e., the cost of the amputations. Congress made this law 25 years ago. Congress should fix it.

The bipartisan Managed Care Reform Act of 1999 would help prevent a case like little Jimmy Adams and it would help make health plans responsible for their actions. To my Republican colleagues, I call out.

We talk about people being responsible for their actions. We think a murderer or a rapist should be responsible for his actions. We think an able-bodied person should be responsible for providing for his family and for his children. Well, my fellow Republicans, HMOs should be responsible for their actions, too. Let us walk the talk on responsibility when it comes to HMOs just as we do for criminals and for deadbeat fathers.

Now, the opponents to real managed care reform always try to inflate fears that the legislation is going to cause premiums to skyrocket, that people would be priced out of coverage. I say to that, not so.

Studies have shown that the price of managed care reform would be modest, probably less than $35 a year for a family of four. In fact, the chief executive officer of my own Iowa Blue Cross/Blue Shield Wellmark plan told me they are implementing HMO reforms and they do not expect to see any premium increases from those changes.

Now, the HMO industry last year spent more than $100,000 per congressman lobbying on this issue and they have been running ads all around the country in the last 2 months. Well, take their numbers with a grain of salt. The industry took an estimate of last year's Patients' Bill of Rights, which was scored by the CBO at a 4-percent cumulative increase over 10 years, but the industry in its ads reported the increase as if it were 4 percent annual instead of 4 percent over 10 years.

The HMO industry also conveniently ignored page 2 of the Congressional Budget Office summary, which said that only about two-thirds of that 4 percent over 10 years would be in the form of raised premiums.

HMOs predict our consequences if Congress passes a bill like the bipartisan managed care bill. They say lawsuits will run rampant. They say costs will skyrocket. They say managed care will shrink. And I say, baloney.

These Chicken Littles remind me of the opponents to the clean water and clean air regulations a decade ago. They all said the sky will fall, the sky will fall if that legislation passed. Instead, today we have cheap air, and we have clean water except for those victims of the hurricane right now.

Let us look at the facts. In the State of Texas, after a series of highly publicized hearings during which numerous citizens told of injury or death resulting of denial of treatment from their HMOs, the Texas Senate passed a strong HMO reform bill making HMOs liable for their decisions by a vote of 25–5. The Texas House of Representatives passed the bill unanimously, and Governor George W. Bush allowed it to become law. And he told me recently, he said, You know what Greg, I think that law is working pretty darn good.

Recently the House Committee on Commerce heard testimony from Texas that refutes those dire predictions by the HMO industry. A deluge of lawsuits? There has been one lawsuit in 2 years since passage of the Texas Managed Care Liability Act.

That lawsuit, Plocica versus NYLCare, is a case in which the managed care plan did not obey the law and a man died. This case exemplifies accountability at the end of the review process. Mr. Plocica was discharged from the hospital suffering from severe acute clinical depression. His treating psychiatrist told the plan that he was suicidal and he needed to stay in the hospital until he could be stabilized. Texas law required an expedited review by an independent review organization prior to discharge, but such a review was not offered to the family or to the man.

Mr. Plocica's wife took him home. That night he drank half a gallon of antifreeze, and he died a horrible painful death because of that HMO's decision.

Now, this case shows that an external review and liability go hand-in-hand. Without the threat of legal accountability, HMO abuses like those that happened to Jimmy Adams and Mr. Plocica will go unchecked. But the lesson from Texas is also that lawsuits will not go crazy.

In fact, when HMOs know that they are going to be held accountable, there will be fewer tragedies like this. And just as there has not been a vast increase in litigation, neither has there been a skyrocketing increase in premiums in Texas.

The national average for overall health costs increased 3.7 percent in 1992, while the Dallas and Houston markets were well below average at 2.8 percent and 2.4 percent respectively. Other national surveys show Texas premium increases to be consistent with those of other States that do not have the extensive patient protection legislations that were passed by the Texas legislature. And the managed care market in Texas certainly has not dried up.

In 1994, the year prior to the Texas managed care reforms, there were 30 HMOs in Texas. Today there are 51. In a recent newspaper article, ETNA CEO Richard Huber referred to Texas as ''the filet mignon'' of States to do business in when he was asked about ETNA's plan to acquire Prudential that has a large amount of Texas business.

None of these facts support the HMO's accusations that Texas patient protection laws would negatively impact on the desire of HMOs to do business in Texas.

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Mr. Speaker, it is time for Congress to get off its duff and fix this problem that it created, and I call on my Republican colleagues to join with us in a bipartisan effort in a couple weeks here to pass this bill.

Mr. Speaker, let me talk for a few minutes about the uninsured, because we are going to hear a lot of debate in 2 weeks about various provisions on the uninsured and how we should not pass patient protection legislation, we should really be dealing with the uninsured.

Now I think, Mr. Speaker, that we definitely need to do something about the uninsured in this country, and let me give you some thoughts on this:

First of all, who is the uninsured? Well, there are about 43 million people without any form of health insurance in this country. About 25 percent of the uninsured are under the age of 19, 25 percent are hispanic, 25 percent are legal noncitizens, 25 percent are poor, which is noteworthy because 46 percent of the poor do not have Medicaid even though they qualify for Medicaid; and these groups overlap so that if you are below the age of 19, you are Hispanic, you are poor and a legal noncitizen, your chances of being uninsured are very, very high.

A significant percentage, however, are not poor. They have incomes of more than two times the national poverty level, and these people tend to be aged 19 to 25. Fewer than 15 percent, Mr. Speaker, fewer than 15 percent of those older than 25, are uninsured, uninsured.

So, if we know these facts, a few solutions kind of leap out at us on how to fix this problem of the uninsured.

First, there are 11 million uninsured children living in this country. One-quarter of the uninsured, about 5 million of these people, qualify for Medicaid, or they qualify for the Children's Health Insurance Program. But they are not enrolled. Hispanic Americans represent 12 percent of the under-65 population, but 24 percent of the uninsured. The income of many Hispanics qualify them for Medicaid, but they, too, frequently are not getting the coverage that they qualify for.

Why is this? Well, Mr. Speaker, a lot of times it is because the Government has not made it particularly easy to access the system. In my own State of Iowa, the application is not only long, but a Medicaid recipient must report

his income each month in order to get Medicaid. In Texas, to be eligible for Medicaid, the uninsured must first apply in person at the Department of Human Services, which is usually located way off the beaten track and way out of range of public transportation.

If even one of the receipts to prove eligibility is forgotten, the applicant has to spend another day traveling and waiting in line. In California the uninsured person who is poor must first fill out, and get this, a 25-page application for Medicaid, often in a language they can barely speak or barely read, and many times English is a second language.

So, Mr. Speaker, the first thing we can do to reduce the number of uninsured is to make sure that the poor who qualify for Medicaid are covered. How do you do that? Simplify forms, reach to Hispanic and other ethnic communities, oversee the CHIP program to see why more people who qualify are not taking advantage. In many cases, Mr. Speaker, it is as simple as the fact that the people who qualify do not even know about the programs.

Now are we going to hear much debate on the floor of Congress here in 2 weeks on doing these things? Or are we going to see some debate on some truly screwy ideas that could hurt the risk pool, and I will talk about that in a minute.

Well, what about those who are aged 19 to 23? Many of these people are in college. This is a healthy group. It should not be expensive to cover. Some colleges say they can cover these young people for only $500 a year for a catastrophic coverage. That is a small price to pay compared to tuition. Why have we not made a commitment to health care coverage for this group? Maybe we should look at tieing student loans to health coverage, and I believe that tax policy also determines to some extent whether an individual has health insurance.

Businesses get 100 percent deductibility for providing health care to employees. Individuals purchasing their own insurance get about 40 percent. That is not fair; let us fix it.

In trying to address the uninsured, however, Congress should be careful not to increase the number of uninsured through unintended consequences of potentially harmful ideas such as I am sure we are going to debate on the floor in about 2 weeks, ideas like health marts and association health plans.

Let me explain my concern, and I hope my colleagues are listening to this:

Under court interpretations of the Employee Retirement Income Security Act of 1974, State insurance officials cannot regulate health coverage by self-insured employers. This regulatory loophole, as I have said before, created many of the problems with association health plans. The benefit of being able to create a favorable risk pool motivated many to self-insure; but since they were exempt from State insurance oversight, many of these association health plans became insolvent during the 1970s and the early 1980s and left hundreds of thousands of people without coverage.

Some of these plans went under because of bad management and financial miscalculations, and others were simply started by unscrupulous people whose only goal was to make a quick buck and get out without any concern about the plight of those who were covered under those association plans.

I would encourage my colleagues to read Karl Polzer's article, Preempting State Authority to Regulate Association Plans, Where It Might Take Us. It is in National Health Policy Forum, October 1997.

Mr. Speaker, we have said this before many times on the floor: those who do not know history are bound to repeat it. Those rash of failures for association health plans led Congress in 1983 to amend ERISA to give back to States the authority to regulate self-insured, multiple-employer welfare associations or association health plans. Only self-insured plans established or maintained by a union or a single employer remained exempt from insurance regulation; and now there are those who want to ignore the lessons of the past and repeat the mistakes of pre-1983. If anything, some mismanaged and fraudulent associations continue to operate. Some associations try to escape State regulation by setting up sham union or sham employer associations; self-insure and then they claim they are not an EWA.

To quote an article by Wicks and Meyer entitled, Small Employer Health Insurance Purchasing Arrangement, Can They Expand Coverage?, it says: ''The consequences are sometimes disastrous for people covered by these bogus schemes,''.

Well, Mr. Speaker, if anything, Congress should crack down on these fraudulent activities. We should not be promoting them, but we are going to have a debate on this floor in 2 weeks where there are going to be people standing here in this well promoting those screwy ideas. I would encourage them to go back and look at history and not repeat the mistakes that were corrected in 1983.

Wicks and Meyer summarized the two big problems with expanding ERISA exemption to more association health plans.

First, if they bring together people who have below-average risk and exclude others and are not subject to State small-group rating rules, then they draw off people from the larger insurance pool, thereby raising premiums for those who remain in the pool. Mr. Speaker, I hope my colleagues are listening. If they vote for association health plans' expansion, your vote could result in an increase of premiums for many individuals in your States.

Second, if they are not subject to appropriate insurance regulation to prevent fraud and ensure solvency and long-run financial viability, they may leave enrollees with unpaid medical claims and no coverage for future medical expenses. Mr. Speaker, that would not help the problem of the uninsured.

Mr. Speaker, I recently asked a panel of experts that appeared before the Committee on Commerce if they agreed with these concerns about association health plans; and they unanimously did, and that panel even included proponents of association health plans.

Mr. Speaker, let us pass real HMO reform. Let us learn from States like Texas. After all, is it not Republicans who say the States are the laboratories of democracy? Well, let us address the uninsured by making sure that those who qualify for the safety net are actually enrolled; and, yes, let us have equity in health insurance tax incentives, but let us also be very leery and wary of repeating past mistakes with ERISA.

Now we are also going to have a debate on the floor here about some substitutes, and I just want to commend my Republican colleagues from Oklahoma (Mr. COBURN) and Arizona (Mr. SHADEGG). They have been forthrightly for health plans being held liable for their negligence, and all of us who have worked on this issue appreciate that. However, I want to advise my colleagues that there is a provision in their bill, H.R. 2824, that is very problematic, and it goes like this:

''Before a patient could go to court, an external appeal entity would have to certify whether a personal injury had been sustained or whether an HMO was the proximate cause of injury.'' A finding for the HMO ends the lawsuit, according to this provision. A finding for the patient would not prevent the patient from making the same argument in court.

So therefore, before a patient could hold a managed care company responsible for wrongfully denying care, he or she would first have to go through an internal appeal, an external review and a secondary external review. That is not a very timely process for a sick patient. And furthermore, the Supreme Court has recently made clear that the Seventh Amendment means the right to have a jury decide all factual issues. In the case Feltner v. Columbia Pictures Television, in the Coburn-Shadegg bill the external entity would decide the elements of horror, the proximate cause and the breach of due care. In short, the entire case except damages.

Well, the Supreme Court in a decision, Grandfinanciere, S.A., v. Nordberg, ruled that Congress may not evade the Seventh Amendment simply by transferring the adjudication of private claims from federal courts to tribunals like this one that do not have juries; and furthermore, the gentleman from Oklahoma (Mr. COBURN) envisions those tribunals to be composed of doctors who probably would not be expert in State or federal law.

So why should this be a problem for anyone in this body? Well, let me give my colleagues an example.

Many in Congress are interested in the rights of the unborn. Case law is developing in State courts on pre-birth and even pre-conception torts, and a majority of States allow for the recovery of pre-birth injuries.

Now these sensitive policy decisions are being made by State legislatures and State courts in case law. They should not be left to private bodies who are not accountable to anyone, which is what would happen under this provision of the Coburn-Shadegg bill. There would be nothing to prevent an external appeal entity from reverting to the notion that a fetus is not a person, and therefore there was no personal injury for birth defects or other harm occurring before birth.

And furthermore, this medical eligibility scheme would be imposed on non-ERISA plans. It is unfair to patients. That provision is one sidedly in favor of HMOs, and it is unconstitutional; and when you get a chance, vote against that provision, and I would point out about 14 States where case law confirms the Supreme Court decisions as well.

Mr. Speaker, 275 groups have cosponsored H.R. 2723, the Bipartisan Managed Care Consensus Reform bill. I will insert the list of these endorsing organizations into the RECORD:

SUPPORT FOR H.R. 2723 IS GROWING EXPONENTIALLY

WHY DON'T YOU JOIN THE MEMBERS OF THE FOLLOWING 275 GROUPS BY COSPONSORING H.R. 2723 TODAY?

Academy for Educational Development; Adapted Physical Activity Council; Allergy and Asthma Network-Mothers of Asthmatics, Inc.; Alliance for Children and Families; Alliance for Rehabilitation Counseling; American Academy of Allergy and Immunology; American Academy of Child and Adolescent Psychiatry; American Academy of Emergency Medicine; American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Family Physicians; American Academy of Neurology; American Academy of Opthalmology; American Academy of Otolaryngology-Head and Neck Surgery; American Academy of Pain Medicine; American Academy of Pediatrics; American Academy of Physical Medicine & Rehabilitation; American Association for Hand Surgery; American Association for Holistic Health; American Association for Marriage and Family Therapy; American Association for Mental Retardation; American Association for Psychosocial Rehabilitation; American Association for Respiratory Care; American Association for the Study of Headache; American Association of Clinical Endocrinologists; American Association of Clinical Urologists; American Association of Hip and Knee Surgeons; American Association of Neurological Surgeons; American Association of Nurse Anesthetists; American Association of Oral and Maxillofacial Surgeons; American Association of Orthopaedic Foot and Ankle Surgeons; American Association of Orthopaedic Surgeons; American Association of Pastoral Counselors; American Association of People with Disabilities; American Association of Private Practice Psychiatrists; American Association of University Affiliated Programs for Persons with DD; American Association of University Women; American Association on Health and Disability; American Bar Association, Commission on Mental & Physical Disability Law; American Board of Examiners in Clinical Social Work; American Cancer Society; American Chiropractic Association; American College of Allergy and Immunology; American College of Cardiology; American College of Foot and Ankle Surgeons; American College of Gastroenterology; American College of Nuclear Physicians; American College of Nurse-Midwives; American College of Obstetricians and Gynecologists; American College of Osteopathic Surgeons; American College of Physicians; American College of Radiation Oncology; American College of Radiology; American College of Rheumatology; American College of Surgeons; American Council for the Blind; American Counseling Association; American Dental Association; American Diabetes Association; American EEG Society; American Family Foundation; American Federation of State, County, and Municipal Employees; American Federation of Teachers; American Foundation for the Blind; American Gastroentrological Association; American Group Psychotherapy Association; American Heart Association; American Liver Foundation; American Lung Association/American Thoracic Society; American Medical Association; American Medical Rehabilitation Providers Association; American Medical Student Associatoin; American Medical Women's Association, Inc.; American Mental Health Counselors Association; American Music Therapy Association; American Network of Community Options And Resources; American Nurses Association; American Occupational Therapy Association; American Optometric Association; American Orthopaedic Society for Sports Medicine; American Orthopsychiatric Association; American Orthotic and Prosthetic Association; American Osteopathic Academy of Orthopedics; American Osteopathic Association; American Osteopathic Surgeons; American Pain Society; American Physical Therapy Association; American Podiatric Medical Association; American Psychiatric Association; American Psychiatric Nurses Association; American Psychoanalytic Association; American Psychological Association; American Public Health Association; American Society for Dermatologic Survey; American Society for Gastrointestinal Endoscopy; American Society for Surgery of the Hand; American Society for Therapeutic Radiology and Oncology; American Society of Anesthesiology; American Society of Cataract and Refractive Surgery; American Society of Dermatology; American Society of Echocardiography; American Society of Foot and Ankle Surgery; American Society of General Surgeons; American Society of Hand Therapists; American Society of Hematology; American Society of Internal Medicine; American Society of Nephrology; American Society of Nuclear Cardiology; American Society of Pediatric Nephrology; American Society of Plastic and Reconstructive Surgeons, Inc.; American Society of Transplant Surgeons; American Society of Transplanation; American Speech-Languge-Hearing Association; American Therapeutic Recreation Association; American Urological Association; Americans for Better Care of the Dying; Amputee Coalition of America; Anxiety Disorders Association of America; Arthritis Foundation; Arthroscopy Association of North America; Association for Ambulatory Behavioral Healthcare; Association for Education and Rehabilitation of the Blind and Visually Impaired; Association for Persons in Supported Employment; Association for the Advancement of Psychology; Association for the Education of Community Rehabilitation Personnel; Association of American Cancer Institutes; Association of Education for Community Rehabilitation Programs; Association of Freestanding Radiation Oncology Centers; Association of Maternal and Child Health Programs; Association of Subspecialty Professors; Association of Tech Act Projects; Asthma & Allergy Foundation of America; Autism Society of America; Bazelon Center for Mental Health Law; California Access to Specialty Care Coalition; California Congress of Dermatological Societies; Center for Patient Advocacy; Center on Disability and Health; Child Welfare League of America; Children & Adults With Attention Deficit/Hyperactivity Disorder; Citizens United for Rehabilitation of Errants; Clinical Social Work Federation; Communication Workers of America; Conference of Educational Administrators of Schools and Programs for the Deaf; Congress of Neurological Surgeons; Consortium of Developmental Disabilities Councils; Consumer Action Network; Consumers Union; Cooley's Anemia Foundation; Corporation for the Advancement of Psychiatry; Council for Exceptional Children; Council for Learning Disabilities; Crohn's and Colitis Foundation of America; Diagenetics; Digestive Disease National Coalition; Disability Rights Education and Defense Fund; Division for Early Childhood of the CEC; Easter Seals; Epilepsy Foundation of America; Evangelical Lutheran Church in America; Eye Bank Association of America; Families USA; Family Service America; Federated Ambulatory Surgery Association; Federation of Behavioral, Psychological & Cognitive Sciences; Federation of Families for Children's Mental Health; Friends Committee on National Legislation; Goodwill Industries International Inc.; Guillain-Barre Syndrome Foundation; Helen Keller National Center; Higher Education Consortium for Special Education; Huntington's Disease Society of America; Infectious Disease Society of America; Inter/National Association of Business, Industry and Rehabilitation; International Association of Jewish Vocational Services; International Association of Psychosocial Rehabilitation Services; International Dyslexia Association; Joseph P. Kennedy, Jr. Foundation; Learning Disabilities Association; Lupus Foundation of America, Inc.; Medical College of Wisconsin; National Alliance for the Mentally Ill; National Association for Medical Equipment Services; National Association for Rural Mental Health; National Association for State Directors of Developmental Disabilities Services; National Association for the Advancement of Orthotics and Prosthetics; National Association of Children's Hospitals; National Association of Developmental Disabilities Councils; National Association of Medical Directors of Respiratory Care; National Association of People with AIDS; National Association of Physicians Who Care; National Association of Private Schools for Exceptional Children; National Association of Protection and Advocacy Systems; National Association of Psychiatric Treatment Centers for Children; National Association of Public Hospitals and Health Systems (Qualified Support); National Association of Rehabilitation Research and Training Centers; National Association of School Psychologists; National Association of Social Workers; National Association of State Directors of Special Education, National Association of State Mental Health Program Directors; National Association of the Deaf; National Black Women's Health Project; National Breast Cancer Coalition; National Center for Learning Disabilities; National Coalition on Deaf-Blindness; National Committee to Preserve Social Security and Medicare; National Community

Pharmacists Association; National Consortium of Phys. Ed. And Recreation For Individuals with Disabilities; National Council for Community Behavioral Healthcare; National Depressive and Manic-Depressive Association; National Down Syndrome Society; National Foundation for Ectodermal Dysplasias; National Hemophilia Foundation; National Mental Health Association; National Multiple Sclerosis Society; National Organization of Physicians Who Care; National Organization of Social Security Claimants' Representatives; National Organization on Disability; National Parent Network on Disabilities; National Partnership for Women & Families; National Patient Advocate Foundation; National Psoriasis Foundation; National Rehabilitation Association; National Rehabilitation Hospital; National Therapeutic Recreation Society; NETWORK: National Catholic Social Justice Lobby; NISH; North American Society of Pacing and Electrophysiology; Opticians Association of America; Oregon Dermatology Society; Orthopaedic Trauma Association; Outpatient Ophthalmic Surgery Society; Pain Care Coalition; Paralysis Society of America; Paralyzed Veterans of America; Patient Advocates for Skin Disease Research; Patients Who Care; Pediatric Orthopaedic Society of North America; Pediatrix Medical Group: Neonatology and Pediatrics Intensive Care Specialist; Physicians for Reproductive Choice and Health; Physicians Who Care; Pituitary Tumor Network; Public Citizen* (Liability Provisions Only); Rehabilitation Engineering and Assistive Technology Society of N. America; Renal Physicians Association; Resolve; The National Infertility Clinic; Scoliosis Research Society; Self Help for Hard of Hearing People, Inc.; Service Employees International Union; Sjogren's Syndrome Foundation Inc.; Society for Excellence in Eyecare; Society for Vascular Surgery; Society of Cardiovascular & Interventional Radiology; Society of Critical Care Medicine; Society of Gynecologic Oncologists; Society of Nuclear Medicine; Society of Thoracic Surgeons; Spina Bifida Association of America; The Alexandria Graham Bell Association for The Deaf, Inc.; The American Society of Dermatophathology; The Arc of the United States; The Council on Quality and Leadership in Support for People with Disabilities (The Council); The Endocrine Society; The Paget Foundation for Paget's Disease of Bone and Related Disorders; The Society for Cardiac Angiography and Interventions; The TMJ Associations, Ltd.; Title II Community AIDS National Network; United Auto Workers; United Cerebral Palsy Association; United Church of Christ; United Ostomy Association; Very Special Arts; World Institute on Disability.

Mr. Speaker, 275 endorsing organizations, nearly all the patient advocacy groups in the country: American Cancer Society, National MS Society. I could go down the list. Nearly all the consumer groups in the country, Consumers Union. You look through the whole list of this; nearly all the provider groups, the physicians, the nurses, the physical therapists, the podiatrists, the opticians. And you know what? This is a patient protection bill.

□ 2015

There is nothing in this bill that provides an advantage for a provider, other than being able to be an advocate for your patient.

This is about letting people solve problems with their HMOs in a timely fashion, through a due process, that gives them a chance to reverse an arbitrary decision of medical necessity by their plan. We should not hesitate about having HMOs be responsible for their decisions.

Surveys show that there is a significant public concern about the quality of HMO care. Despite millions of dollars of advertising by HMOs over the last 8 years, a recent Kaiser survey showed no change in public opinion. Seventy-seven percent favor access to specialists; 83 percent favor independent review; 76 percent favor emergency coverage; and more than 70 percent favor the right to sue an HMO for medical negligence; and 85 percent of the public thinks that Congress should fix these HMO problems.

Mr. Speaker, in a few weeks we are going to get a chance, I hope in a fair way, to debate managed care reform, patient protection legislation. It is none too soon. While we have been dillydallying around for a couple of years now, patients have been injured because of arbitrary decisions by HMOs; and some of them have lost their lives. We need to address this issue soon, and we can do it in a bipartisan fashion. And I would encourage Members on both sides of the aisle to fight off the poison pill amendments that we are going to see under the rule, fight off the substitutes, some of which will be like the ones from the Senate which are really HMO protection bills, and join with us, 275 endorsing groups, millions and millions of people out in the country who are calling on Congress to pass H.R. 2723, the bipartisan consensus managed care reform bill.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 1875, INTERSTATE CLASS ACTION JURISDICTION ACT OF 1999

Mr. HASTINGS of Washington (during the special order of Mr. GANSKE), from the Committee on Rules, submitted a privileged report (Rept. No. 106–326) on the resolution (H. Res. 295) providing for consideration of the bill (H.R. 1875) to amend title 28, United States Code, to allow the application of the principles of Federal diversity jurisdiction to interstate class actions, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 1487, NATIONAL MONUMENT NEPA COMPLIANCE ACT

Mr. HASTINGS of Washington (during the special order of Mr. GANSKE), from the Committee on Rules, submitted a privileged report (Rept. No. 106–327) on the resolution (H. Res. 296) providing for consideration of the bill (H.R. 1487) to provide for public participation in the declaration of national monuments under the Act popularly known as the Antiquities Act of 1906, which was referred to the House Calendar and ordered to be printed.

PATIENTS' BILL OF RIGHTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I must say that I am so pleased to be following the special order of my colleague, the gentleman from Iowa (Mr. GANSKE), because he addressed the same issue that I would like to address this evening and that is the need for HMO reform and the need to bring legislation to the floor of this House which we refer to as the Patients' Bill of Rights because it provides protection for Americans who are patients who happen to be members of HMOs or managed care organizations; and those protections are needed right now.

They were needed a long time ago, but it is really time that the Republican leadership of the House of Representatives allow this bill to come to the floor to be debated, and I believe it will pass overwhelmingly.

I must say, I have been on this floor many times over the last year, or even beyond, asking that the Republican leadership allow the opportunity for the Patients' Bill of Rights to come to the floor, and we were told last Friday for the first time that the Speaker has set the week of October 4, approximately 2 weeks from now, for that opportunity.

Although I have to say that I am suspicious of the way that this will be brought to the floor and the procedure and the rules that will be followed; and I know that my colleague, the gentleman from Iowa (Mr. GANSKE), mentioned that as well. I must say that I am pleased that we will be debating HMO reform and that one of the bills that we have been promised by the Speaker that will be brought to the floor is the Patients' Bill of Rights.

I really need to emphasize this evening, as I have so many other times on the floor and this well, that there are differences between the various managed care reform proposals that have been proposed here and that even though it is true that the Republican leadership now says that they will allow debate on the Patients' Bill of Rights, they have also made it quite clear that they are going to favor bills other than the Patients' Bill of Rights and that there may and certainly will be an effort to pass alternative legislation to the Patients' Bill of Rights.

I need to urge my colleagues not to fall into the trap of thinking that anything other than the new bipartisan Patients' Bill of Rights is acceptable, not only to us but to the American people.

I wanted to point out that it has been very interesting. Really, just last Wednesday, I guess, September 13, in the New York Times, there was an article that talked about how the GOP leadership was very cool on our patients' rights plan and how they were