about John F. Kennedy, Martin Luther King or even, for that matter, Rodney King.

The District of Columbia public school system was sued this summer for allowing a church to use an abandoned park as a parking lot in exchange for providing after-school services for the neighborhood children. The September 17 story, as reported in the Washington Post, revealed that members of the Metropolitan Baptist Church have been parking about 300 cars on the field on Sundays for more than 10 years. Reverend Hicks agreed to cancel the contract rather than force the city to defend the suit. Reverend Hicks, pastor of the 5,000-member Metropolitan Baptist Church of Washington, D.C. got my attention with his statement when announcing plans to terminate the contract, saying there has been a shift in culture, he said. We have reached the point where God no longer has a place in our communities.

Mr. Speaker, imagine that. A simple contract between the city and the church, where the city says to the church they can use this parking lot on Sundays that would otherwise be vacant and unused if they will provide an after-school service, an opportunity for these children; and somebody challenges that because of their fear of religion and the city is forced to submit.

The Hagerstown Suns, a Single-A affiliate of the major league Toronto Blue Jays, is being sued by the ACLU because they ran a promotion for the past 6 years that reduced ticket prices on Sundays for anyone coming to the stadium with a church bulletin.

According to the Baltimore Sun in their June 29 edition, the ACLU believes this discount is a form of discrimination against the nonreligious.

Jeff Jacoby complains in his August 19 column in the Boston Globe of a blatant case of anti-religious bias involving an inner city Boston church. On July 15, the City of Boston sent a letter to Mason Cathedral warning the church center, which receives taxpayer subsidies to help wayward youth, not to involve its teenage counselors in religious activities, including but not limited to the following: praying, reading Bible stories, drawing Bible pictures, and cleaning in the areas of the church where there are religious symbols. All religious activities must cease immediately.

Jeff Jacoby interviewed the pastor: ''For 5 years, they have been saying I do good work,'' says Reverend Thomas Cross. ''This year, everything has changed.''

Conversely, if anyone stood up and said that the groups like the National Organization of Women and the National Abortion Rights League should not be allowed to operate shelters for battered, homeless women because they cannot separate out their political agenda, they would be laughed right off the stage.

Amazingly, our own Federal Office of Juvenile Justice Delinquency Prevention even funds the middle school curriculum ''healing the hate.'' Get this, Mr. Speaker, our own Federal Office of Juvenile Justice Delinquency Prevention even funds a middle school curriculum entitled ''healing the hate'' that suggests that among the warning signs for school counselors that a child may be dangerous is if he or she grows up in a very religious home.

□ 1345

Mr. Speaker, I know of no religion, I know of no religion that preaches hate, violence, or even, for that matter, disrespect for other people. Yet, we have a Federal Government office that puts together a program that says that, if one identifies a child of faith, one should see that child as a threat to his companion children.

Mr. Speaker, this is done without any shred of evidence showing any linkage whatsoever between Christians and any of these terrible acts of violence that our Nation has faced. Imagine saying that a warning sign that a child may be dangerous or a threat to other classmates was the skin color or sexual orientation of that child's home. Such a statement would be declared outrageous or condemned in every quarter of the land.

In case after case, people of faith are told to mind their own business, keep to themselves, and stay out of the affairs of the rest of society. People of faith are called the extremists, labeled out and out threats to our Nation, and generally find ''Not Welcome Here'' signs all over the place.

Law-abiding people who regularly attend church, try to live their lives as examples to their children and their community are lampooned and mocked. Priests, ministers, and the laymen who support them are expected to sit at the back of the bus when it comes to participating in the public square.

As my colleagues have seen from my examples, when the rights of people of faith are trampled, newspapers and other leaders in our Nation are either silent or complicit. Why is this? What about the rights of people of faith?

Bigotry of any kind, Mr. Speaker, should be confronted. It is always irrational, and it is always unjustified. Madmen who kill at a synagogue deserve our most stinging disapprobation. The tragic death of James Byrd was worthy of the national condemnation. But just as we should be eternally vigilant against racial bigotry, we must also protect the rights of people of faith.

People of faith, Mr. Speaker, are decent, loving, and patriotic. They work hard to provide for their families and are tireless advocates for improving our communities across the Nation. Let us join together and condemn those who would deny freedom and opportunity for every American.

Mr. Speaker, let us have the simple common American decency to respect each and every person who feels within their heart the need to express their faith and respect of other people. We must deal with these circumstances, Mr. Speaker, honestly and assertively.

We are a great Nation. We are a Nation that has been declared in the past to be a good Nation, a Nation of good people. No matter what our prosperity, no matter what our power, we cannot be that if we cannot be a Nation that has the decency to respect the faith of our citizens. We are failing in that regard, and we must turn it around.

MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. LATOURETTE). Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for 45 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, I thank the Majority Leader for yielding me the balance of his time.

One can never say that the floor of Congress is a dull place. So this afternoon we have heard about art exhibits showing the blessed virgin with elephant dung on them. We had a 5-minute speech from the gentleman from Minnesota (Mr. RAMSTAD) who had told us that he lives in Lake Woebegone. So I am going to speak about managed care.

I just thought I would ask the Majority Leader a question. I was wondering if the Majority Leader, in the spirit of a little levity, could tell me the difference between a PPO, an HMO, and the PLO.

Mr. ARMEY. Mr. Speaker, if the gentleman will yield, I will rise to debate. Let me say to the gentleman, though, I am sorry I cannot tell him the difference between a PPO, an HMO, and a PLO.

Mr. GANSKE. Well, Mr. Speaker, one can negotiate with the PLO.

Mr. Speaker, I am going to use the balance of the time to discuss managed care reform legislation that we are going to be debating here on the floor next week. I appreciate the Majority Leader and the Speaker of the House for setting up this debate for next week.

The rumors are that we will be using the bipartisan consensus managed care bill as the base bill. That is the bill that I support. It is a strong managed care reform bill.

We are uncertain at this time as to what type of rule we will have. I would request that we have a clean rule; in other words, a rule that is limited to patient protection legislation and does not involve tax matters for which one could then get into discussions about offsets and other difficult problems.

Well, Mr. Speaker, humor sometimes shows that the public is aware of a problem. I remember, a few years ago, my wife and I went to the movie ''As Good As It Gets.'' Many people saw this movie. It featured Helen Hunt and Mr. Nicholson.

It was about a waitress played by Helen Hunt. She had a young son who

had asthma. In one of the lines of the movie, which I cannot repeat here on the floor, Helen Hunt, with expletive waste language described her HMO as preventing her son who had asthma from getting the type of care that he needed. The forcefulness of her statement caused audiences, not just to laugh, but in many instances to stand up and clap and cheer, as occurred in the movie theater that my wife and I attended this movie, indicating that the public understands that there is a problem in the delivery of health care by HMOs.

It is not so funny when we look at real life cases. We have headlines, and this probably is directly related to the humor or at least the understanding of the statement by Helen Hunt in the movie ''As Good As It Gets.'' We have a headline here from the New York Post: ''HMO's cruel rules leave her dying for the Doc she needs.'' Just like the HMO's cruel rules would not allow Helen Hunt's son in the movie to get the asthma care that he needed, so he was also ending up in the emergency room.

How about this headline from the New York post: ''What his parents did not know about HMOs may have killed this baby.''

Which brings us to an issue in HMO reform that we have been working on which deals with an issue that started this debate several years ago.

Now, before I came to Congress, I was a reconstructive surgeon in Des Moines, Iowa. I still go overseas and do charitable surgery. So I am still involved with the practice of medicine in some respects.

But a few years ago, it became known that HMOs were writing contracts in which they said that, before a physician could tell a patient all of their treatment options, they would first have to get an okay from the HMO. These are called gag rules. That then spawned a number of cartoons.

Here we have one, and I will read this for my colleagues because it is hard to see. We have a physician sitting at his desk, and he says: ''Your best option is cremation, $359, fully insured.'' The patient is sitting there saying, ''This is one of those HMO gag rules, isn't it, doctor?''

Or how about this one. The physician is sitting, talking to his patient. The physician says, ''I will have to check my contract before I answer that question.''

Now, think of that. Now say one is a woman, one has a lump in one's breast, and one goes in to see one's doctor, he takes one's history, does one's physical exam. Then he says, ''Excuse me. I have to leave the room.'' He goes out in the hallway. He has to get on the phone, phone the HMO, and says, ''Mrs. So-and-So has a lump in her breast. She has three treatment options, one of which may be expensive. Is it okay if I tell her about all three treatment options.''

Is that bizarre? Is that ridiculous? Does that strike at the heart of a patient having confidence that his physician is going to tell him all of his treatment options.

Well, it was not such a funny story for a real life patient. This woman in the middle of this picture is dead today because her HMO prevented her from knowing all of her treatment options. This story is fully documented in Time Magazine from about 2 years ago.

Or how about the problem that one has had with HMOs in delivering emergency care. Frequently, HMOs, if one has gone to an emergency room, will deny payment.

Let me give my colleagues an example. You wake up in the middle of the night. You have crushing chest pain. You are sweaty. You know that the American Heart Association says this could be a sign that you are having a heart attack. So you go to the emergency room right away like you should, because if you delay, you may be dead. You have the tests run, and the electrocardiogram shows it is normal. But, instead, you have severe inflammation of your stomach or your esophagus.

So the HMO, ex post facto, says, ''See, the EKG was normal. You were not having a heart attack. You are stuck with the bill, man, because you did not need to go.''

Next time somebody thinks about that and then delays going to the emergency room when they should under what a common layperson would say is truly an emergency, they may not get a second chance.

So here you have a cartoon that sort of deals with this. You have a medical reviewer saying, ''Cuddly Care HMO. My name is Joan. How may I help you? You are at the emergency room, and your husband needs approval for treatment? He is gasping, writhing, eyes rolled back in his head? Does not sound all that serious to me.'', the medical reviewer at the HMO says.

Then she says, ''Clutching his throat? Turning purple? Uh-huh? Have you tried an inhaler? He is dead? Well, then, he certainly does not need treatment, does he?''

Then the medical reviewer from the HMO turns to us and says, ''Gee, people are always trying to rip us off.''

That is black humor. That is black humor, I will tell my colleagues. But that rings a bell with a lot of people who have trouble with their HMOs.

Here you have a picture from a TV show a long time ago. You have a nurse here. She is on the phone, and she is saying, ''Chest pains? Let me find the emergency room preapproval forms.''

How about a real life example of an HMO patient having significant problems with their HMO during an emergency. This young woman who is strapped to a board was hiking not too far from Washington. She fell off a 40-foot cliff. She was lying at the base of the cliff, semi-comatose with a fractured skull, a broken arm, and a broken pelvis.

Fortunately, her boyfriend had a cellular phone, and they got her airlifted into an emergency room. She was in the ICU on morphine drip for a long time, but she is doing okay now. But then she got a refusal of payment from her HMO. They would not pay for her hospitalization. Do my colleagues know why? They said, well, she did not phone ahead for preauthorization.

I mean, think of that. She was supposed to know that she was going to fall off the cliff, break her skull, break her arm, fracture her pelvis. Maybe her HMO thought that, as she was laying at the bottom of the cliff, she should wake up, with her nonbroken arm, pull a cellular phone out, dial a 1–800 number, and say, ''Hello. I just fell off a cliff. I broke my pelvis. I need to go to the emergency room.''

□ 1400

And then when she was in the hospital on a morphine drip in the ICU, after it became silly, when the HMO was confronted with their denial, they said, well, she was in the hospital and she did not notify us in the first couple of days, so now we are not going to pay for it on that reason.

Well, she was finally able to get some help from her State ombudsman, but many people who have health insurance, particularly through their employers, would not have that option. So what we have in the bill that we are talking about, the patient protection bill, the bipartisan consensus managed-care reform bill, is a provision that says, look, if an average person has what they would say truly is an emergency, they get to go to the emergency room and the HMO has to pay.

How about some of these plan guidelines the HMOs use to determine medical necessity. Remember these? Remember when the HMOs were talking about drive-through delivery of babies or mandating only 24-hour stays in the hospital? Boy, they were embarrassed by that. But under Federal law, they can define medical necessity anyway they want to. And even if a patient suffers an jury, they have no recourse under Federal law.

Here we have a cartoon with Dr. Welby, and he is saying, ''She had her baby 45 minutes ago. Discharge her.'' I mean, imagine that line on that program years ago. People would have thought that was absolutely crazy, and yet that is what the HMOs have mandated in some cases.

Here we have a cartoon that says maternity hospital, and then we have the drive-through window with the caption, ''Now only 6-minute stays for new moms.'' And the person at the window says, ''Congratulations, would you like fries with that?'' And look at the mother. Her hair is all out like this; the baby is crying. And then there is a little thing that says, ''Looking a little like scalding coffee situation,'' in the corner.

Now, this may be a little bit funny, but it was not funny to a woman by the name of Florence Corcoran, whose baby was sent home within the mandated 24

hours. The baby ended up dying of an infection that would have been discovered had the baby been allowed to stay in the hospital just a little bit longer.

I was talking a little bit about the HMO's ability under Federal law for employer plans to define medical necessity any way they want to. Well, I have taken care of a lot of children with this birth defect, a cleft lip and a cleft palate. There are some HMOs out there that are defining medical necessity as the ''cheapest, least expensive care.'' Think of that for a minute. They can deny any treatment that is not the cheapest, least expensive care.

So for this child with this birth defect, instead of authorizing a surgical correction of the roof of this child's mouth that would enable the child to be able to learn to speak correctly, not to mention not having food go out of his nose, that HMO, under Federal law as it currently exists, could say, no, that is not the cheapest care. We are going to prescribe a little piece of plastic to shove up in that hole in the roof of the mouth, what is called an obturator. Of course, will the child be able to learn to speak properly with that? No. But quality does not matter to the HMOs when they are defining care as the cheapest, least expensive care. And under Federal law they could do that with impunity. We need to fix that.

Here we have another cartoon. We have the operating table. We have the doctors, the HMO bean counters, and anesthesiologist at the head of the table. And the doctor says, scalpel. The HMO bean counter says, pocketknife. The doctor says, suture. The HMO bean counter says, Band-Aid. The doctor says, let us get him to intensive care. And the HMO bean counter says, call a cab.

They can do that under current Federal law, because they can define medical necessity as the cheapest, least expensive care.

Here is a cartoon that says, ''Remember the old days, when we took refresher courses in medical procedures?,'' one doctor is saying to a colleague as they walk in the HMO medical school. And the course directory in the HMO medical school is: First floor, basic bookkeeping and accounting; second floor, advanced bookkeeping and accounting; third floor, graduate bookkeeping and accounting.

Now, look, I think some HMOs do a reasonable job, and they should be a choice for people to have. And some HMOs are truly trying to do an ethical job as well. But the HMO field is very competitive, particularly on prices, and there are some bad apples out there that are cutting corners too close. And they are able to do that because this Federal law that I was talking about that passed 25 years ago put nothing in place of State insurance oversight. It took the oversight on quality away from the States. Not a very Republican idea. It took it away from the States, put it in the Federal arena, but then placed nothing in its place in terms of some standard rules on fairness to patients or on quality.

Here we have another cartoon that says, ''the HMO bedside manner.'' ''Time is money'' is the sign on the edge of the bed. ''Bed space is loss. Turnover is profit.'' And the health care provider is saying, ''After consulting my colleague in accounting, we have concluded you're well enough. Now, go home.'' And here we have a patient with his arms in traction looking like he has a fractured face with his jaw in traction.

The bottom line should not be the bottom line if it is going to interfere with quality health care.

Here we have another cartoon where the patient is saying to the HMO physician, ''Do you make more money if you give patients less care?'' The HMO spokesperson says, ''That's absurd, crazy, delusional.'' The patient then says, ''Are you saying I'm paranoid?'' And the answer is, ''Yes, but we can treat it in three visits.''

It reminds me of the well-known joke about the three physicians who died and went to heaven. One of them was a neurosurgeon, and he said to Saint Peter, You know, I fixed people who were in accidents and had blood clots on their brains and I saved their lives. And Saint Peter said, Enter my son. The next person is an obstetrician, and she says to Saint Peter, I have delivered hundreds of thousands of babies, and I have given a lot of free care. And Saint Peter says, Enter, my daughter. And the last one is an HMO medical director who says, Well, Saint Peter, I was able to save millions of dollars by denying care and getting people out of the hospital earlier. And Saint Peter says, Enter, my son, for 3 days.

Here we have a cartoon that is the HMO claims department, and the HMO bureaucrat says, ''No, we don't authorize that specialist.'' Then she says, ''No, we don't cover that operation.'' And then she says, ''No, we don't pay for that medication.'' And then, apparently, there is some strong language or something as she is listening, and then she looks rather cross and says, ''No, we don't consider this assisted suicide.''

Now, look, if all of this seems a little off the wall, let me just say that it has real-life consequences when HMOs are not accountable for their medical decisions. And is there anyone that doubts that HMOs are making medical decisions every day? Not by the hundreds, not by the thousands, but by the tens of thousands every day they are making medical decisions. And under Federal law they are not liable for the bad results, the negligent results of those decisions that could result in loss of life or limb.

Now, if an insurance company sells a policy as an individual, and they are under State insurance oversight, that insurance company does not have that kind of legal liability shield. But under this antiquated Federal law, it is the only group in this country, other than foreign diplomats, that have legal immunity for the decisions that they are making. The automobile manufacturers do not have that kind of legal immunity, the airplane manufacturers or the airlines do not. Only the group that provides health care for employers is totally immune from the consequences or responsibility of their decisions.

So let me tell my colleagues about a case where this makes a real difference, where an HMO made a medical decision. I have here a picture of a little boy who is tugging his sister's sleeve. He is about 6 months old. A few weeks after this picture was taken he is awake at about 3 in the morning with a temperature of about 105, and he is sick. And as a mother can tell, he is really sick and he needs to go to the emergency room.

So Mom does what she should do. She phones that 1–800 number for that HMO and says, My baby, Jimmy, is sick. He has a temperature of 104, 105, and he needs to go to the emergency room. And this voice from some distant place, certainly not familiar with her State, says, Well, all right. I will authorize you to take little Jimmy to this hospital. And Mom says, Well, where is it? And the reply from the medical bureaucrat is, Well, I don't know. Find a map.

Well, it turns out that it is a long ways away. But Mom and Dad know that if they take little Jimmy to a different hospital, then their HMO is not going to cover any of the cost. So they wrap up little Jimmy and start the trek. Halfway through the trip they pass three emergency rooms with pediatric care facilities that could have taken care of little Jimmy, but they cannot stop. They are not medical professionals, but they do know if they stop at those unauthorized hospitals they would be stuck with potentially a huge bill. So they keep driving.

Before they get to the hospital that has been designated, little Jimmy has a cardiac arrest and he stops breathing, and his heart stops beating. Imagine that, while Mom and Dad are driving, Mom is trying to keep this beautiful little boy alive.

They come screeching finally into the emergency room. Mom leaps out screaming, Help me, help me, help my baby. A nurse runs out and does mouth-to-mouth resuscitation. They start IVs, they give him medicines, they pound his chest, and they get him back alive. But because of that medical decision that that HMO made, they do not get him back whole. Because of that circulatory arrest, he ends up with gangrene of both hands and both feet. And they have to be amputated.

Here is little Jimmy after his HMO treatment, sans hands and sans feet. Under Federal law, the HMO which made this medically negligent decision is liable for nothing, zero, nada, because they have already paid for his amputations, and that is all they are liable for.

Is that fairness? Is that justice?

This little boy will never play basketball. I would remind the Speaker of

the House that this little boy will never wrestle. I would remind my colleagues that some day when he grows up and he gets married he will never be able to caress the cheek of the woman that he loves with his hand. I would remind the HMO people who always say do not legislate on the basis of anecdotes like little Jimmy Adams that this little boy, if he had a hand and you pricked his finger, it would bleed.

We need justice. I am a Republican. I have stood on this floor and I have voted for responsibility for one's actions. If a murderer or a rapist is convicted, they should suffer the consequences. When we passed the welfare reform bill, we said it is your responsibility if you are able-bodied and you could work, it is your responsibility to get some education. We will help you with that, but you need to get out and get a job and support your family.

Republicans are big on responsibility. But look, are my fellow Republicans going to say to the HMOs when they are responsible for a little boy losing his hands and feet that that HMO should not be responsible? And furthermore, we Republicans have said, you know what, we should devolve power back to the States. Let us get these things back to the States. This was a Federal law that took this oversight away from the States.

In the name of justice, we should say that if an HMO makes this type of decision that results in this type of injury, they should be responsible for that. That is only fair.

I will tell my colleagues what: Those bottom-line HMOs that are cutting the corners too close will be much more careful so we will not see injuries like this. A judge reviewed this case. The judge, in reviewing the HMO's decision making on this, said that their margin of safety was ''razor thin.'' I would add to that, as razor thin as the scalpel that had to cut off little Jimmy's hands and feet.

What we are talking about next week when we have this debate is an issue that has a lot of importance to people every day around the country. We will have an opportunity to correct a wrong, to right a wrong. The bill, as it was written in ERISA 25 years ago, did not anticipate the changes that we have seen in the management of health care by HMOs where they are now managing medical decisions.

I am a physician. I would never argue that if I had made a negligent decision that had resulted in an injury like this that I, as a physician, should be immune from the consequences. I do not know any physicians who would make that argument.

I do not know an airplane manufacturer that, if it is negligent and a plane goes down and 200 people are killed, would make an argument on this floor that anyone would vote for that would give them legal immunity for their negligent actions. I just do not see it.

Well, Mr. Speaker, we are going to have an opportunity to debate several bills next week. There is a difference in those bills. There is a bill that my good friends, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG), have introduced.

I would point out that the Health Insurance Association of America does not think that that is a very good bill because of the liability provisions that it has in it. But I would say that there are some problems with that bill.

Let me give my colleagues an example. They have a provision in the bill that requires the exhaustion of all remedies and the internal and external review procedures in order to permit a cause of action against an HMO that would make this type of decision. I think that is a problem.

For example, a patient like little Jimmy Adams could have already suffered an injury or he could have died before he ever went through an appeals process. Or, for instance, a patient might not discover an injury that is a result of an HMO decision until after the time period in which administrative remedies of internal and external review could have been used.

There are some significant problems in the way that liability provisions are written, and I would encourage my colleagues to not support it.

We are going to debate on the floor possibly a medical access bill. I think that bill should be handled on a separate bill. We will have to deal with that issue in the rule. But when it comes to the floor, I would encourage my friends to be very careful about the Talent-Hastert bill.

Let me just read to my colleagues a press release that was put out by the Health Insurance Association of America. This is the insurance folks. On this issue I think they are correct.

They say, there are two provisions in the plan announced by the gentleman from Illinois (Mr. HASTERT) that are cause for concern. ''HIAA opposes the plan's call for Association Health Plans and HealthMarts because they would hurt many small employers who provide coverage to their employees.'' Let me repeat that. This is the insurance industry talking about a bill to increase access. They oppose Association Health Plans and HealthMarts because they would hurt many small employers who provide coverage to their employees. ''This, in turn, will cause many of these employers to drop their coverage because it will become too costly.''

A press release from the same organization speaks about a similar provision in the bill of the gentleman from Ohio (Mr. BOEHNER). His bill ''contains expensive mandates and problematic Association Health Plans and HealthMarts.''

Then we have a press release that says, ''These bills,'' referring to bills that have Association Health Plans and HealthMarts, ''could destroy employer-sponsored health insurance.''

I have a memo from the Blue Cross-Blue Shield Association entitled ''Association Health Plans: The Unraveling of State Insurance Reforms.''

I have another memo from Blue Cross-Blue Shield Association Health Plans. ''Association Health Plan legislation would require billions in Federal regulatory spending.''

Here is another memo from the Blue Cross-Blue Shield plan. Association Health Plan legislation would reduce insurance coverage. I have another memo from the Blue Cross-Blue Shield Association Health Plan. ''Study claims coverage would increase under Association Health Plan legislation is fundamentally flawed.''

I am pointing this out because of this bill that I support, the bipartisan consensus managed care bill, we do not have Association Health Plans in it.

Here is another memo from Blue Cross-Blue Shield. ''Association Health Plan legislation would increase administrative costs for small businesses.''

Here is another memo from Blue Cross-Blue Shield Association Health Plan. ''National survey finds that small businesses reject this type of legislation.''

Mr. Speaker, we will soon have, hopefully, a full debate on the floor on patient protection legislation. There is one bill that has generated the endorsement of over 300 organizations around the country. We have not seen this type of coalition since the days of the civil rights bills. These are all of the patient advocacy groups, the consumer groups, the professional provider groups on board, the American Cancer Society, the American Heart Association, the American Lung Association. You could go down the list. They support one bill. And that is H.R. 2723, the bipartisan consensus managed care improvement act of 1999.

This is a bill that has reached across the aisle. It has come to a reasonable compromise on the liability issue. It says that an employer is not liable if an employer has not entered into the decision making that the contracted HMO has made.

I have a clear legal brief that says our language is rock solid on that protection for employers. It says that if there is a dispute, a patient can then take that denial of care from the HMO and take it to an independent panel in order to get that reversed by the HMO. But, in fairness to the HMO, if they follow independent panel's recommendation, then the HMO is no longer liable for any punitive liability.

This is a fair compromise, and it applies across the board not just to group health plans but to all plans. This would apply to insurers who are in the individual market, as well. That would be a good thing. That would be not leading to lawsuits but preventing injuries so that you do not end up with a little boy who has lost his hands and his feet.

This is a fair compromise, Mr. Speaker. Let us gather together. Let us get past the $100 million that the HMO industry is spending to defeat this legislation. Let us do something right. Let

us agree with the American public that says, by an 85 percent margin, we think Congress should pass Federal legislation to protect patients from HMO abuses like this one.

Mr. Speaker, next week we will have a historic opportunity to show whether we, as individual Members of Congress, are on the side of patients or on the side of the HMO bureaucrats. Support H.R. 2723.

Mr. Speaker, I include the aforementioned articles for the RECORD:

AHP/MEWA STUDY: NATIONAL SURVEY FINDS THAT SMALL BUSINESSES REJECT MEWA LEGISLATION

Performed by: American Viewpoint, Inc.; Sponsor: BCBSA; April 15, 1998.

American Viewpoint, Inc., conducted a national survey of small business owners and employees in order to assess their views on proposed regulatory reforms regarding Multiple Employer Welfare Arrangements (MEWAs) and Association Health Plans (AHPs). A total of 500 interviews were conducted with small business owners and 300 interviews were conducted with employees of small businesses. Interviews were conducted by telephone between March 20 and April 15, 1998.

SUMMARY AND CONCLUSIONS

After arguments on both sides of the debate are presented, small business rejects this proposal by 42%–26%. That is, 42% say Congress should not pass it and just 26% support passage.

By 54%–21% small business owners and employees say their state insurance commissioner is better able than the U.S. Department of Labor to regulate health insurance in their state.

In fact, there is very little confidence in the U.S. Department of Labor's ability to enforce the law without a major increase in the size of the bureaucracy. Only 17% think the Labor Department could enforce the law while 68% say it cannot.

Overall, anti-federal government sentiment is a major factor in the opposition to proposed legislation on MEWAs and AHPs. In all, 63% are less favorable and only 26% are more favorable toward the legislation when they learn that these plans would be regulated only by the federal government—not by the states.

SMALL BUSINESS DOES NOT FAVOR THE USE OF FEDERAL LEGISLATION TO AVOID STATE LAWS

63% are less favorable toward the legislation, and 20% are more favorable, in response to the argument that this legislation ''creates a large loophole through which healthy small employers and certain individuals could exit the state regulated markets, leaving only the sickest remaining in these insurance pools.''

59% are less favorable and 26% more favorable toward the legislation when they learn that plans would be exempt from other state laws such as limits on out-of-pocket expenditures and requirements to include certain specialists.

A majority (55%) are less favorable toward the legislation when they learn that it would exempt affected small group health plans from more than 1,000 consumer protection laws at the state level. Only 24% are more favorable.

54% are less favorable (31% are more favorable) toward the legislation because it would allow health plans to operate without having to comply with each state's laws on premiums, benefits, and financial standards.

Fairness is also an issue. A majority (54%) say it is not fair that exempting these groups from state regulations would allow them to escape the cost of state assessments for programs to help low-income and high-risk individuals who are unable to find affordable health coverage.

A majority (52%) say that federally-regulated group health plans should not be allowed to have lower financial standards than those now required by the states. Only 23% say they should be allowed to have lower standards.

Small employers are very sensitive to price. A 55% majority say they would not be able to continue offering insurance if their premiums went up by 20%. One in three say they would be unable to continue offering insurance to their employees if premiums rose by 10%.

Clearly, anti-federal government sentiment is a major factor in small businesses' rejection of the AHP legislation. However, several other factors are also important considerations. First, they think the bill is unfair to those with a less healthy work force. Second, they think it would lower standards for exempted plans and expose them to health and financial risks from which they are now protected under state law. Third, only one in three think the bill would have a positive impact on their ability to provide health insurance.

In short, although small business may agree with the motivations for this legislation, they realize that the bill itself threatens their ability to provide health insurance to employees, the quality of their coverage, the security of the state-regulated insurance pools, and the quality of insurance regulatory oversight. As a result, a plurality (35%) would be less likely to vote for a Member of Congress who supports this legislation and just 27% are more likely. 22% say it depends.

Note: The margin of error for a random sample of N=800 is ±3.5 percentage points at 95% confidence. The margin of error for N=500 is ±4.5 percentage points and the margin for N=300 is ±5.8 points.

AHP/MEWA STUDY: ASSOCIATION HEALTH PLAN LEGISLATION WOULD INCREASE ADMINISTRATIVE COSTS FOR SMALL BUSINESSES

Performed by: William M. Mercer, Inc.; Sponsor: BCBSA; March 22, 1999.

An analysis by the benefits consulting firm of William M. Mercer found that AHPs/MEWAs have unique administrative costs, such as royalties and membership dues, that make it more expensive for small firms to purchase coverage through these groups. Moreover, Mercer found that general administrative costs for AHPs/MEWAs are similar to insurance companies and that this legislation provides no opportunity for AHPs to reduce administrative costs for small firms.

KEY FINDINGS:

Associations often require additional administrative loads: According to a 1995 survey of associations, 80% of group health insurance programs sponsored by associations produce revenue for the association. Association revenue comes from marketing fees, administrative fees, and royalties and licensing fees. Association-specific fees can be substantial. According to one survey, association administrative fees averaged 3.8%, while royalties (i.e., licensing fees charged to insurers) average 2.2% of premiums for national plans.

Association membership fees can add to the cost of coverage: Association membership fees are an additional cost that must be borne by small firms that purchase health coverage through an AHP. ''As a result of the fees required to join an association, firms and individuals may face higher total costs in the association market than they would if they purchased coverage directly from a health insurance company without joining an association.''

AHPs and insurers have similar administrative costs: ''Administrative costs borne in the small group market would generally apply to federally certified AHPs as well.'' Sales commissions, employer billing, and underwriting expenses tend to be higher for small employers as compared to those for large employers. However, offering small group health plans through AHPs does not eliminate these costs.

AHPs would not reduce administrative costs: ''Based on our review, this legislation would provide no material opportunity for AHPs to reduce health insurance administrative costs for small businesses.'' AHPs could assume responsibility for administrative activities. ''However, it is unlikely that AHPs could perform these activities at lower cost than insurers. Negotiating prices with vendors that are below the insurers' costs would be equally unlikely.''

Mercer concludes that, ''. . . for small group health plans offered by AHPs, the potential administrative cost increases typically would exceed the potential administrative cost savings. We estimate that the additional costs for small firms who buy AHP coverage typically would range from 1.5% to 5% of premiums.''

AHP/MEWA STUDY: STUDY CLAIMING COVERAGE WOULD INCREASE UNDER ASSOCIATION HEALTH PLAN LEGISLATION IS FUNDAMENTALLY FLAWED

Performed by: Barents Group/KPMG; Sponsor: BCBSA; February 12, 1999.

A recent analysis by the Barents Group/KPMG found that a National Federation of Independent Business (NFIB) funded study that asserted that AHP legislation would help solve the uninsured problem contains serious deficiencies that undermine its credibility. Moreover, the NFIB study, performed by CONSAD Research Corp., neglects the primary problem with this proposal: that it would undermine state reforms, thus reducing access for many small employers.

The Barents Group's review of the NFIB study found problems that ''. . . raise serious concerns regarding the accuracy of the estimates.'' Given these problems, Barents concluded that ''. . . the report fails to provide an adequate justification for the assertion that coverage would increase under the proposed association health plan (AHP) legislation.'' Flaws identified include:

Unsubstantiated claims of AHP savings: The projected increase in coverage is based on assumed savings for AHPs of between 5 and 20 percent. According to Barents, ''. . . these assumptions . . . are not based on any evidence that such savings would actually exist. In fact, other studies have shown that AHPs would actually increase costs for many small firms by skimming off employers with healthy workers and undermining state reforms.''

Unrealistic assumptions: Barents found the results of the NFIB study to be ''. . . implausible because they are inconsistent with the existing body of literature on working health insurance coverage.'' For example, the study inflates the estimates by assuming that people are three to six times more likely to buy coverage than one would expect based on the academic literature.

Use of inflated numbers: The base population used for the estimate is ''inflated, which results in overestimation of the number of people who would obtain coverage.'' For example, it appears that individuals covered by Medicare, Medicaid and other public programs may also be in this base, despite the fact that they would typically not participate in AHPs.

Neglecting the effects of income on the decision to purchase insurance: The report fails to account for the fact that low-wage workers would be less likely to obtain coverage. ''The net effect of not accounting for affordability is to overestimate the number of workers that would obtain coverage,'' according to the Barents analysis.

The Barents analysis supports BCBSA's position that the principal effect of this legislation would be to force employers to move from the small group insurance market to AHPs—not increase the number of people with insurance. As the Barents analysis points out, ''. . . if AHPs are successful in reducing costs by attracting a healthier risk-pool, any increase in coverage could be offset by reductions in coverage for the rest of the small group market.''

AHP/MEWA STUDY: ASSOCIATION HEALTH PLAN LEGISLATION WOULD REDUCE INSURANCE COVERAGE

Performed by: Len Nichols, Ph.D., of the Urban Institute; June 16, 1999.

Although association health plans are touted as a ''solution'' for the uninsured, preliminary results of an Urban Institute study indicate that AHP legislation would actually *reduce* overall health insurance coverage. The results of this study, which were outlined in testimony by Len Nichols, Ph.D. before the House Commerce Health Subcommittee, reaffirm concerns raised by numerous groups regarding the potential for this legislation to undermine state reforms and make coverage more expensive for firms and individuals with greater health care needs.

KEY FINDINGS

AHPs will be most attractive to healthy individuals: According to Nichols, ''. . . our research simulations suggest that by far the most important factor determining the attractiveness of various health insurance options is the pool with whom the firm's workers will be joined for premium rating purposes. AHPs and Health Marts . . . will be more attractive to the good risks and less attractive to high risks in search of more heterogeneous pools.''

AHPs would undermine pooling in the insurance market: AHPs will appeal to good risks since they can practice more segmented premium rating practices than the commercial insurance industry. . . . This segmentation increases the chances that firms will be pooled only with firms with similar cost structures.'' In other words, AHPs will fragment the insurance market into smaller and smaller pools, rather than increasing pooling as proponents claim.

AHPs will pull people from existing insurance arrangements, rather than attract the uninsured into the market. Nichols found that ''. . . extremely few new firms are enticed to offer health insurance which did not offer [coverage] before the reform options were made available. The net effect would be a lot of churning of insurance policies, but few uninsured would gain coverage and some firms with insurance would drop coverage.

AHPs will result in more uninsured Americans. Nichols said his projections indicate that ''net coverage is reduced because the commercial and [existing] MEWA pools lose some of their best risks to the AHPs, and thus their pools deteriorate. Because of this risk pool deterioration, some firms drop coverage rather than pay the new higher prices that go with this deteriorating risk pool. These firms do not join the AHPs . . . because that risk pool is too segmented for their taste and risk profiles.''

These preliminary results are part of a growing body of literature that refutes claims that AHP legislation would reduce costs for small firms or help the uninsured. BCBSA believes that AHP/MEWA legislation would raise costs for many small firms without making any progress toward solving the uninsured problem.

AHP/MEWA STUDY: AHP LEGISLATION WOULD REQUIRE BILLIONS IN FEDERAL REGULATORY SPENDING

Performed by: Bill Custer, Ph.D. and Martin Grace, Ph.D., Georgia State University; Sponsor: BCBSA; June 2, 1999.

In this update of a 1996 study of MEWA regulatory costs, Georgia State University researchers Bill Custer and Martin Grace conclude that AHP legislation would create a significant regulatory burden for the federal government. They estimate that billions of dollars in federal regulatory outlays would be needed to oversee AHPs. Moreover, they conclude that provisions that allow federal officials to cede regulation of certain AHPs back to the states would require the creation of a duplicative regulatory system that would actually increase overall regulatory costs.

KEY FINDINGS

The proposal requires major new regulatory outlays: Custer and Martin estimate that regulatory costs would increase by between $431 million and $3.2 billion over a seven-year budget period. Federal regulatory costs could be as high as $2.4 billion over seven years, while state regulatory costs could exceed $1.1 billion.

The AHP proposal creates new federal bureaucracy: The legislation requires federal officials to create a new regulatory bureaucracy to regulate AHPs, which are now overseen by the states. ''Although the federal government already has regulatory responsibility for ERISA plans, AHP regulation should result in significantly higher federal regulatory costs. The Department of Labor (DOL) has testified that they have the resources to review each ERISA health plan once every 300 years. This level of oversight will not be adequate for AHPs, which are much more like insurers than single-employer health plans.''

The proposal creates costly dual regulation scheme: Custer and Grace dismiss proponents' claims that allowing states to enforce certain federal standards will limit regulatory outlays. ''In fact, the most costly regulatory model is one in which the federal and state governments take an equal role in regulating AHPs, which is the most likely regulatory model under this legislation. This is because dual regulation would require both the federal government and the states to develop and maintain duplicative and costly regulatory systems.''

Undermines state insurance laws: Many states have passed reforms that limit insurers' ability to compete on the basis of risk. Although the legislation attempts to limit the ability of AHPs to exclude groups on the basis of claims experience, ''. . . the primary factor in deciding to form one of these groups will be risk. . . . As such, both insured and self-funded AHPs would pull better risks out of the small group market, increasing premiums for those who remain in the state-regulated market or are without access to the association plan.''

[Blue Cross Blue Shield Association, Washington, DC, September, 1995]

AHPS/MEWAS: THE UNRAVELING OF STATE INSURANCE REFORMS

As Congress considers federal health care reform, Congress should reject proposals to exempt Association Health Plans (AHPs) and Multiple Employer Welfare Arrangements (MEWAs) from state law and regulation. These proposals would unravel insurance reforms that most every state has enacted to assure access to health insurance for small firms and their workers.

Rather than enhancing the ''pooling'' of small firms, as claimed by AHP/MEWA proponents, this legislation would lead to smaller and smaller insurance pools as healthy groups leave the state market. The result will be large premium increases for many firms and more uninsured.

WHAT ARE AHPS/MEWAS?

Association Health Plans are health plans sponsored by business and professional groups. Many AHPs exist today under state regulation and can play a valuable role in providing health coverage to their members. Associations and other business groups that provide health benefits to two or more employers are generally called Multiple Employer Welfare Arrangements (MEWAs).

MEWAs can self-fund or purchase insurance from health plans that are regulated by the states. States currently have authority to regulate MEWAs and require self-funded MEWAs to comply with state insurance standards because they are risk-bearing entities and operate like insurers.

IMPACT OF CONGRESSIONAL PROPOSALS TO PREEMPT STATE LAW FOR AHPS/MEWAS

Congressional AHP proposals would exempt self-funded AHPs/MEWAs from state law and transfer oversight to the Department of Labor (DOL). These entities would be exempt from numerous state standards, including solvency requirements, managed care rules, benefit mandates and certain rating laws. Minimal federal standards would replace state rules. This change would:

Allow AHPs/MEWAs to ''Cherry-Pick'': Exemption from state mandated benefits would allow MEWAs to avoid offering benefits that attract sick individuals (such as autologous bone marrow transplants). This proposal also would allow AHPs/MEWAs to be experience rated, rather than pooled with other small groups for rating purposes, as required in many states. Despite certain rules against discrimination in the proposal, AHPs/MEWAs could be designed and marketed in a manner that would attract members with lower expected health care costs.

Destroy State Insurance Reforms and Increase Premiums: Preemption of self-funded AHPs/MEWAs from state regulation would allow a large segment of the health insurance market to escape state regulation. The movement of healthy individuals into self-funded arrangements would leave high risk individuals in the insured pool, but reduce the number of enrollees over which to spread costs. The resulting premium increases would drive away more healthy individuals and ignite another round of premium increases. States would be unable to stabilize rates because such a large portion of individuals would be outside their authority.

Increase the Number of Uninsured: Rather than being a solution for the uninsured, a recent Urban Institute analysis found that AHP legislation would actually reduce overall health insurance rates. According to testimony by Dr. Len Nichols of the Urban Institute, net coverage is reduced because the state-regulated pools lose some of their best risks to the AHPs, and thus the pools deteriorate. Because of this risk pool deterioration, firms drop coverage rather than pay the new higher prices that go with this deteriorating risk pool.

Transfer Insurance Regulation to the Federal Government: This proposal would allow large numbers of AHPs to avoid state rules through self-funding. The number of plans regulated by DOL would increase dramatically, requiring a significant increase in federal regulatory capacity. Under the current

staffing structure, DOL could review each AHP only once every three hundred years, which is inadequate for these new federally licensed insurance arrangements. The regulatory burden for these AHPs could be up to $3.2 billion over 7 years, according to a recent analysis by researchers at Georgia State University.

Expose Federal Government to Monumental Regulatory Responsibilities: by transferring regulatory authority to the federal government, DOL would become responsible for regulating the solvency of hundreds of AHPs/MEWAs across the country. MEWAs have a history of fraud and have left thousands of consumers and providers facing millions of dollars in unpaid medical claims. The National Governors' Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners have stated that solvency standards in the proposal remain inadequate to protect consumers.

BCBSA also opposes proposals to apply special rules (i.e., ratings and exemption from mandated benefits) to insured AHPs/MEWAs. These rules would allow insured AHPs to be experience rated instead of pooled with other small groups and individuals. This provides an opportunity for segmentation of the market. The end result: higher premiums, an unstable market and states that are powerless to address the problem because federal law has overridden their authority.

BCBSA RECOMMENDATION

BCBSA believes that the federal government should allow states to retain the authority to regulate the health insurance market. States are the most appropriate decision-makers to craft legislation that expand across without disrupting insurance markets. However, the federal government should take an active role in encouraging small firms to provide health coverage though targeted tax incentives, such as the small employer tax proposal that BCBSA unveiled in February of this year.

[Press Release—Health Insurance Association of America, September 29, 1999]

NEW ''PATIENT PROTECTION'' BILLS COULD DESTROY EMPLOYER-SPONSORED HEALTH INSURANCE

WASHINGTON, DC.—Despite the assertions of Congressional sponsors, new so-called ''patient protection'' legislation would allow employers to be sued over health benefits voluntarily provided to their employees, and could destroy the employer-based health insurance system, according to a new legal opinion released today by the Health Insurance Association of America (HIAA).

The new HIAA legal opinion demonstrates that the Shadegg-Coburn bill introduced last week—as well as the ''Dingwood'' bill introduced last month—expressly authorize lawsuits against any employer shown to exercise any oversight over its health coverage. The opinion also states that the ''shield'' in both bills—which the bills' sponsors claim would protect employers against lawsuits—would apply only if an employer gives up any involvement with any coverage decision.

Under these bills, even an employer's simple act of choosing health coverage for employees would be considered exercising oversight over health coverage, thereby exposing the employer to the possibility of a lawsuit.

''This legal opinion shows how both bills offer employers who sponsor health coverage a 'Hobson's choice' between the horrific and the horrendous,'' remarked HIAA President Chip Kahn. ''Employers either could pay for higher cost coverage that they cannot control, or retain control and expose themselves to costly lawsuits. Given these choices, many employers are likely to throw in the towel and simply drop coverage altogether, leaving millions more Americans uninsured.''

HIAA's new legal opinion was prepared by Washington, D.C.-based attorney William G. Schiffbauer.

HIAA is the nation's most prominent trade association representing the private health care system. Its members provide health, long-term care, disability, and supplemental coverage to more than 115 million Americans.

[Press Release—Health Insurance Association of America, September 29, 1999]

BOEHNER ''CARE'' BILL A MIXED BAG

The following statement was released today by Chip Kahn, President of the Health Insurance Association of America (HIAA):

Consumers and employers can take some solace that the ''Comprehensive Access and Responsibility in Health Care (CARE) Act,'' offered today by Rep. John Boehner (R-OH), would not saddle them with higher premiums due to expanded liability. Our nation's health care dollars should go toward providing coverage for Americans, and for improving quality-not for lining the gilded pockets of trial attorneys.

Although Rep. Boehner's bill prudently lacks liability, it does contain certain costly mandates and a problematic provision calling for ''Association Health Plans'' and ''HealthMarts.'' HIAA opposes Association Health Plans and HealthMarts because they would undermine-not enhance-the small employer market by increasing premiums for many, and causing many of them to drop their coverage because it will become too costly.

On the one hand, Rep. Boehner's bill lacks liability, and would make coverage more affordable because it calls for an immediate, above-the-line deduction for the purchase of individual health and long-term care insurance. On the other hand, Rep. Boehner's bill contains expensive mandates and problematic Association Health Plans and HealthMarts. All told, Rep. Boehner's bill becomes a mixed bag of pluses and minuses for American consumers and employers.

[Press Release—Health Insurance Association of America, September 29, 1999]

WELL-INTENDED HASTERT PLAN HAS PLUSES AND MINUSES

The following statement was released today by Chip Kahn, President of the Health Insurance Association of America (HIAA):

Speaker Dennis Hastert (R–IL), along with Reps. Jim Talent (R–MO) and John Shadegg (R–AZ), clearly recognize the need for increasing the number of Americans with health insurance. The proposal that they released today is a step in the right direction because it would allow a 100 percent tax deduction for individuals and for self-employed Americans. Also, it would provide a similar deduction for private long-term care insurance, and allow people to set up Medical Savings Accounts (MSAs).

In this respect, their proposal is similar to HIAA's ''InsureUSA'' proposal. HIAA also commends the Speaker and Reps. Talent and Shadegg for recognizing that expanding liability provisions undoubtedly will increase costs and force employers to drop coverage for their employees.

Two provisions in the plan announced by Speaker Hastert are well-intended, but are cause for concern. HIAA opposes the plan's call for Association Health Plans and HealthMarts because they would hurt many small employers who provide coverage to their employees. This, in turn, will cause many of these employers to drop their coverage because it will become too costly.

OZONE POLLUTION IN MAINE

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

Mr. BALDACCI. Mr. Speaker, the issue that I and other Members in the chamber are going to be talking about tonight is ozone pollution. Primarily it is pollution coming in from the Midwest from utilities and smoke-stack emissions that is, through the weather patterns, ending up turning Maine into the tailpipe, so to speak, for the Nation, and where you are sitting there at Acadia National Park, one of the most beautiful national monuments, and watching the lighthouses and lobster boats and recognizing that this past summer we had 12 days where there was an ozone problem and we have no industries, no industrial manufacturing of any kind, but it is coming in because of this ozone transport from utilities that are burning coal to generate power and going along in a weather pattern and pollution created all throughout that region.

Now, this issue had been addressed in the Clean Air amendments that were passed in 1992 and these utilities were given exemptions because they were told at that particular time that they would be no longer in business. But because of improvements that they have been able to make in terms of their longevity, they are still going on and they are still polluting the air.

Not only is this something that further undermines the competition for the region, because in the Northeast and in our State of Maine we have made the improvements to the industrial manufacturing sector and they have reduced the amount of pollution that the industries within our State and within our region make, but at the same time, because we have had to expend that money to clean up our air and our water and the region in the Midwest has not had to go through that where they have an economic competitive advantage.

On top of that, the pollution that is created from this ozone transport is damaging the young people and their lungs, older people with asthmatic conditions. It is damaging our agricultural crops.

The other ways that these emissions can harm our environment is that the nitrogen deposit into watershed contributes to the over fertilization of coastal and estuary water systems. Too much nitrogen in these water bodies result in increased algae growth, which limits the oxygen available to sustain fish and other aquatic life.

Although contributions from the years vary from place to place, according to the EPA's Great Waters Report, an estimated 27 percent of nitrogen entering into the Chesapeake Bay can be attributed to air emissions. These nitrogen deposits over-fertilize the land; and when this happens, nitrogen can no