

liability against the employer is strictly limited to cases where the employer directly participated in the denial of benefits. We need to make clear that punitive damages are strictly limited or not allowed. We need to require exhaustion of external review.

We need to be certain that where we allow quality of care actions, we make clear in the law what quality of care is, so that people know what the law is and can set up their health care plans accordingly, and we do not have that judgment being made in State courts around the country.

The reason, again, is because all of this makes a difference to real people who are really confronted with illness and the threat of illness. There are too many people in the United States today, Mr. Speaker, who do not have health insurance, and most of them do not have health insurance because it costs too much. Every time we increase the cost of health insurance, it means more and more people are not covered. Patient protections do not help you if you do not have insurance.

We have the chance in the next couple of days to pass good bills to increase accessibility, to increase the availability of private health insurance to people who do not have it, good private health insurance to these employees of small employers. We have the chance to hold HMOs accountable to get people in treatment rooms where they ought to be, not at home ill and untreated, and not in courtrooms afterwards, after they become seriously ill.

We can do these things. We have that opportunity. I want to close by saying that I welcome the fact that the bills have come this far. There are many competing factions in this House, and it is because of the passion and the energy of those factions that we have a bill and we have the opportunity to vote on it.

I have been working intensively on this for 2 years. I have wanted to see this day come. I am glad we have this opportunity. But let us not do something that will hurt the very people that we are trying to help. Let us not punish the employers and the small employers in this country and their employees by driving up the cost of health insurance to them in a way that is not necessary to ensure the kind of accountability that we all seek in the health care system.

□ 2030

GENERAL LEAVE

Mr. GREEN of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the subject of the special order by the gentleman from Iowa (Mr. BOSWELL).

The SPEAKER pro tempore (Mr. WELDON of Florida). Is there objection to the request of the gentleman from Texas?

There was no objection.

TEXAS' EXPERIENCE WITH MANAGED CARE REFORM: A MODEL FOR THE NATION

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

Mr. Speaker, I want to thank you and also thank our minority leader for allowing me to have this second hour tonight and follow the gentleman from Missouri. Obviously, I agree with the gentleman from Missouri (Mr. TALENT) because Missouri has been the "Show Me State" all of my life, and for the next hour from Texas we are going to show him why he is wrong in his statements.

Mr. Speaker, I would like to first talk about that in the last 2 years in Texas we have had basically the same law that we are trying to pass here tomorrow and Thursday, and the examples offered by the gentleman from Missouri just do not hold water, at least they have not in the State of Texas.

First a little background. Before I was elected to Congress, I actually helped manage a small business in Houston, a printing business. One of my jobs in that business was to shop for our insurance and to make sure our 13 or so employees had adequate coverage, because our company was under a union contract and we could buy it from the union benefit plan or buy on our own if it was either equivalent or better, and so we did that.

And having experience of shopping for a number of years for insurance as both a manager and one who had to make sure we also paid the bills at the end of the week so we could afford it, I bring that kind of experience of a small business, even though I do not serve on the committee.

The other thing I would like to mention, the gentleman talked a great deal of time about threats of suits for employers, and it is not in the intention of myself or the sponsors of the Norwood-Dingell bill that employers will be responsible unless they make those medical decisions. I have offered in my own district and even here in Washington to the National Association of Manufacturers, give me the language and we will sponsor it as an amendment to make sure that employers are not held liable unless they are putting themselves in the place of a health care provider or health care decision-maker. That is saying to their employees, No you cannot do this or you cannot do that.

Again, having been a manager, I know that sometimes employers and businesses can afford a Cadillac plan that pays for a lot. Sometimes they can only afford a Chevy plan that does not pay as much. But just so they are getting what they are paying for, for

their employees; and that is what I think the managed care reform and HMO reform issue is about and it has been about for the last 2 years.

Let me follow up too, the gentleman had mentioned that this bill does not cover Federal employees. Well, right now as a Federal employee or as a State government employee, we have the right to sue our insurance company. We have the right under our plan. All we are trying to do with this bill is to provide to all the other Americans some of the same rights as Members of Congress have. And also it covers the Federal insurance plans, whether it be BlueCross or whatever other plans, because there are so many of them that the consumer would have the right to go to the courthouse ultimately.

So there was a lot of things the gentleman said during his time; and hopefully during the next hour we will hear a lot of folks who have real-life experiences from the State of Texas, because we have had a Patients' Bill of Rights under State law for over 2 years, and it only covers insurance policies that are licensed by the State of Texas.

That is why we have to pass something on the Federal level, because 60 percent of the insurance policies in the district I represent come under ERISA, come under Federal law. Even though the State of Texas 2 years ago passed these very same protections, we have to do it on the Federal level to cover the citizens of Texas who do not come under the State insurance policy.

In fact, this next hour hopefully we will have a lot of folks, and people who like to hear Texas accents will hear them for the next hour, because we will talk about the Texas experience with a little bit of help from some of our Texas colleagues and some from other parts of the country.

Mr. Speaker, let me address some of the issues. The insurance industry and managed care organizations and HMOs have been repeatedly trying to scare the American people saying the bill that we are going to vote on, the Norwood-Dingell bill, would dramatically raise premiums and force employers to drop health insurance. I even heard one of the special interest groups say that this number would be as high as 40 percent.

Mr. Speaker, once they have spread all of this inaccurate information, let me give the experience that not only we have in Texas but also from the Congressional Budget Office. The Congressional Budget Office is a non-partisan agency. They analyzed the Patients' Bill of Rights and said that the best they could determine, that the cost to the beneficiaries under the Patients' Bill of Rights may cost \$2 a month. That is less than the cost of a Happy Meal to provide fairness and protection and accountability.

But in the State of Texas, even if one does not agree with the Congressional Budget Office, and sometimes I disagree with their estimates, we need to look at real-life experience for the last

2 years in Texas. Again, Texas passed this same legislation in 1997, and it became effective in September of 1997; and so we have had over 2 years of experience.

In Texas the patient protections included a consensus HMO reform bill that had external appeals and also the accountability issue, the liability. And over the first 2 years there has been no significant increase in premiums. In fact, the analysis shows that the first quarter of 1999, premiums in Dallas and Houston have increased about half the national average.

And we know there are lots of things that go into increases in premiums, particularly with HMOs because of some of the problems they have now. They tried to expand so rapidly, and now they are having to contract and they are also increasing their premiums; but they are doing it around the country.

So in Texas we have not seen any increase in 2 years in health insurance premiums attributable to the Patients' Bill of Rights. In some cases it is attributable to the increased cost for prescription medication or for other reasons. Health care costs in Texas have increased 4 percent in the first quarter compared to 8 percent in the rest of the country. These estimates are based on reality provided by the Texas Medical Association, and it is more than a theoretical study that should be our guide for the HMO debate.

Moreover, beyond the slim cost of the increase, there has been no exodus by employers to drop health insurance coverage, nor has there been any exodus by patients to go to a courthouse.

Mr. Speaker, in an earlier life I was licensed to practice law, and I have to admit we do not have any shortage of plaintiff's lawyers in Texas who will go to court if they have that opportunity. But, again, in the 2 years we have had it, we have not seen more than four suits, and I will talk about that later in the hour if we get to it. But four lawsuits in Texas. Although we have a fifth one that may be out there, but one of them was by one of the insurance companies challenging the law.

So what Texas residents have is health care protections that they needed, and they are enjoying them now; and as Members of Congress we owe the duty to provide those same protections on a nationwide basis. Unfortunately, instead of recognizing the affordability and value of the consensus bill tomorrow, the Norwood-Dingell bill, our Republican leadership seems poised to repeat last year's actions and come up with imitation bills, and we will talk about those over the next hour also.

But I see my colleague, the gentleman from San Antonio, Texas (Mr. RODRIGUEZ). Before he came to Washington, he served in the Texas legislature for a number of years. He knows it is not easy to pass major legislation there unless it is consensus. In fact, the gentleman was in the State legislature in 1997 when Texas passed that

law, and I yield to my colleague from San Antonio.

Mr. RODRIGUEZ. Mr. Speaker, as a State representative from Texas I know the situation well, and we in Texas are known for the blue bonnets, the Texas barbecue and the champion San Antonio Spurs, the beautiful Rio Grande; but we are also known for the changes that we have made in managed care reform.

Two years ago, Texas was fortunate to have the foresight to enact and implement its own managed care reform. The days and nights prior to that passage are very similar to tonight and this week here in the U.S. Congress where the discussions are over one side that says that health care costs are going to skyrocket and the other side, the good side, saying that we cannot compromise the health care even at the expense of losing one individual for the almighty dollar.

I am of the thinking that health care should not be about compromising anyone's life, but rather about health care and promotion and education.

Two major issues that have helped address the health care concerns of consumers in Texas are the external review process and the ability to hold an HMO liable through a lawsuit. Through the external review process, hundreds of individuals in Texas have the opportunity to have their cases heard by an outside party. The decisions are made by the doctors chosen by an independent medical foundation. The doctors review the cases and render a decision based on that information.

The best part of it is that it is done in a timely manner. In Texas we take pride in that we mandate the review to occur within 14 days and in cases of life or death, for them to move within 3 days in making those life-threatening decisions.

What is even better is that what the doctor says goes. It is not the way we have it right now where an accountant or an insurance person is the one dictating what should happen versus what the doctor is saying.

Nearly 600 cases have been handled in this manner through the external and internal review in Texas and guess what? Half of them have been ruled on behalf of the patients. So it has gone 50-50. So we feel it has been a very fair system that has been working.

For the States that are not fortunate to have this law, I believe that we need to pass Federal legislation here on the Federal level that will ensure that all Americans, not just Texans, have that opportunity to have a due process.

A testament to the fact that the Texas' system works is evidenced through the story that was told in an article by the U.S. News and World Report in March. The story is about a young boy, little Travis, who had a medical condition that came from the fact that he had difficulty breathing. And I was hearing the comments by the previous gentleman out here talking about the external review process

being useless. The gentleman should tell that to little Travis. That was the difference between life and death.

Because of his condition, his doctor asked the HMO to authorize an on-duty nurse. Hard to believe, but the HMO later refused to pay for that nurse. An internal review of the case by the HMO doctor ended up upholding the HMO decision, so the first internal review they sided with the HMO. But thank God the next step was the external review. An outside doctor reviewed the case and found that little Travis was, indeed, entitled to that nursing care. And this is a case with the HMO playing with a little boy's life and it is a serious situation.

Mr. Speaker, thank God he lived in Texas. Each time he stopped breathing, he and his parents knew that he was within moments of suffocating. Having a nurse on hand part-time provided the necessary care for little Travis who needed it when his parents were not around. The external review process works for many, but for those that do not have that access, it cannot work. We have got to assure that those individuals have access to that opportunity.

For the positive happening for little Travis's case, it is great. But there are too many out there who still suffer under those situations.

I would also like to mention that I believe that the ability to sue HMOs in Texas, there was a lot of talk about the fact that there was going to be a lot of lawsuits and that everyone was going to be sue happy. This is not the case, and we have had it there over 2 years. So the reality is, and I will challenge my colleagues, do not be fearful. It is not going to happen. In the State of Texas only five lawsuits have been filed. Think about it. It is a State of 4 million individuals that are in managed care with only five lawsuits that have been filed.

Members can say what they will about managed care reform, but in Texas it has been working. It is alive and well and serving the best interests of those individuals under managed care.

Mr. Speaker, I want to also just congratulate my fellow colleagues and I yield to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, before my colleague leaves, and I appreciate the gentleman being here, let me give some updated information on the appeals process in Texas. As of August of 1999, during the month of August there were only 23 requests for the independent review. But from November 1 of 1997 to the present, the total requests were 626 appeals in those 2 years. 610 of them were completed. The number they upheld was 47. The number of overturned was 46. And partially overturned was 42. So what we are seeing is about 50-50 for the external appeals process.

Again, they are not clogging up the process, but what they are doing is

making sure people have a right to go outside and ask for an appeals process. They do not really want to go to court in Texas. The 2 years we have had that there have been so few lawsuits, but we have had a lot of appeals and people are getting the health care that they need and these appeals are being done quick. They ask for them, and they can complete them almost within that 30 days.

□ 2045

So instead of waiting for 2 years to get to the courthouse, they are actually able to get that health care that they need. That is what is so important.

Again, in the last 2 years since November, a little less than 2 years because the actual appeals process went into effect November 1 of 1997, again half the decisions are in favor of the insurance company, and about a little over half are in favor of the patient.

So what that means is that I feel much more comfortable as a patient that, instead of the chance of a flip of the coin, that we have a better percentage of upholding HMO's decisions or managed care decisions if they had it. But they are losing about half of them in Texas, actually a little more than half.

So that is why it is so important that we pass on a national level a real strong external review process backed up by the accountability.

The reason we do not have the lawsuits in Texas and what is estimated by the people at home is that we have a good, tough external review process where people get their case heard, they get their health care; or they lay out their case, and they do not receive their health care because they are not entitled to it.

It is tough to go to court after one has been through that external review process and find out that one really does not have enough that even an independent review does not do it.

What worries me is that the Republican leadership this year, with what we are going to do tomorrow, there is going to be a number of other plans that will be considered, every one of them is found lacking in what we need to do.

It is so important that we adopt the Norwood-Dingell bill, it is a consensus bill, a bipartisan bill, and attack or defeat the poison pills that are really there just to cloud the issue and not provide the health care that we need.

Let me talk a little bit about the concern about one of the amendments to move these suits to Federal court. Again, in Texas, they go to State court. Again, having practiced law, I do not have a lot of Federal experience in Federal courts, but there was a reason for that. I would much rather go before judges that are elected than judges on the Federal level.

My worry is, if we move these cases to Federal court, that they will be there for years and years and years. If they have to go to court, one needs to go the quickest one can if one has to.

In Texas, we have not had but three or four cases, maybe five at the most, in 2 years. That is why moving to Federal court in one of the amendments tomorrow would be wrong. It would actually be against the patients ability to have justice.

Mr. Speaker, I yield to the gentleman from East Texas (Mr. TURNER). Again, the gentleman from Texas (Mr. TURNER) served as a State representative in Texas, State Senator, in fact was a State Senator in 1995 when the first Patients' Bill of Rights was passed by the legislature and vetoed by the Governor at that time. But in 1997, he let it become law without his signature. I am glad Governor Bush did that in 1997 and saw the error of his ways.

Mr. TURNER. Mr. Speaker, all three of the Texans here tonight served in the legislature, and we all have fought for this issue in our State legislature, and that is one of the reasons we feel so strongly about the fact that the protections that we have provided in law for all Texans should be protections that every American enjoys.

I am glad to see the gentleman from Iowa (Mr. GANSKE) here tonight who is a medical doctor who has fought hard on the Republican side to help pass the Norwood-Dingell bill, also referred to as the Bipartisan Consensus Managed Care Improvement Act, which I think aptly describes the bill that we are trying to pass because it has been crafted with bipartisan support.

It has been worked on for many, many months. Those who have worked on it have been responsive to any concern that has been expressed about it. We are convinced that it is the right bill, and this is the right time to pass these protections for all Americans.

As the gentleman from Texas (Mr. GREEN) mentioned, I was in the Texas Senate in 1995 when the Texas legislature passed the first patient protection legislation in the country. That bill, unfortunately, was vetoed by Governor Bush.

The legislature came back in Texas in 1997 and passed similar legislation once again, broke it down into four separate bills. Three of those bills were signed by the Governor. The fourth he allowed to become law without his signature.

Unfortunately, when we passed the bill the first time in 1995, even though we passed it with overwhelming support, over 90 percent of the members of each house voting in favor, we passed it at the end of the session, and the Governor was able to veto it without an opportunity to overturn the veto.

But we are here tonight to try to provide the same kind of protections for all Americans that we provided for Texans in 1997.

When we passed that bill in 1995 and again in 1997, we had no idea that it would not apply to all Texans. But an insurance company went to court shortly after we passed our legislation and it had become law, and the courts ruled that a Federal law preempted our

State law, and that all insurance plans covered by the ERISA law that the gentleman from Texas (Mr. GREEN) referred to at Federal law meant that those protections that we had provided in our State legislature did not apply to all of those plans that were multi-State plans covered under the Federal ERISA law.

So we have a very awkward situation all across the country today because State after State after State have passed patient protection legislation to protect their patients. Yet, we find there is a Federal law standing in the way that has basically meant that about 40 percent of all the folks that are insured in this country under managed care are not covered by the basic patient protections that their State legislatures have passed over the last 2 and 3 years.

So the Norwood-Dingell bill is designed to change that, to be sure that all people enrolled in managed care plans have the same protections that we believe are just common sense.

Things like ensuring that a patient can go to the nearest emergency room when he has an emergency. Rights like being able to go to the doctor in your own town rather than going to a doctor in an adjoining community. Rights like having access to go to a specialist when one needs one when one's doctor says he wants to refer one to a specialist. Basic rights like not being forced to change doctors and hospitals right in the middle of one's treatment just because one's employer happens to change their managed care company. Basic protections like making sure that medical decisions are made by doctors, not by insurance company clerks.

These are the basic protections that we provided in Texas in 1997, and these are the basic protections that we want to provide for all patients across the United States in the Norwood-Dingell bill.

One of the things that always amazes me, we faced it in 1995 in Texas, we faced it in 1997 in Texas, and now we are facing it here in Washington in 1999, with the managed care companies saying that the sky is going to fall if we pass this legislation. They are claiming that health care costs are going to go up.

They had even gotten the folks who carry their insurance for the employers and the business community all worked up and speaking out against this bill because they think the cost of insuring their employees is going to go up.

As the gentleman from Texas (Mr. GREEN) pointed out, the Congressional Budget Office says the cost of this legislation would be less than \$2 a month per patient. Very small cost in my judgment to protect patients.

When it comes right down to it, business people in this country care very much about their employees and their employees health care. I think most businessmen and women understand

that, when they sign up with an insurance company to provide health insurance for their employees, they want a plan that is going to take care of those employees.

Right now, we have a situation where these basic protections are not guaranteed, and some managed care companies, I understand, today, are already providing these, but many are not.

I really think it would be a lot easier for the average businessman or woman in selecting health insurance for their employees to know that every plan, no matter what proposal is laid on their desk, and no matter what price is offered to them for coverage of their employees, that they know these very basic common sense protections are in every plan.

Right now, I think health care is in turmoil in this country. Doctors are not happy, having to make ten and twenty phone calls to a managed care company just to get something approved that they know their patient needs.

I have talked to these doctors. They are really frustrated with the system as we know it today. I have talked to patients who wonder why they cannot get simple care from a specialist simply because their plan denies them access to a specialist. They do not understand that kind of treatment. They do not understand why they cannot go to an emergency room and have a doctor in the emergency room make a decision as to whether or not there is an emergency rather than having to get on the phone and call the insurance company clerk in some far-off city and find out whether or not they can receive emergency treatment. Those kind of basic protections patients deserve. Employers who want to take care of their employees want this kind of protection for their employees as well.

The truth of the matter is, if we are going to have a health care system in this country that works for everybody, the employers, those who are insured, the doctors, and other health care providers, we need to pass this legislation, because the further we go down the road and find patients being abused and managed care companies doing a shoddy job of rendering care, the more we are going to undermine what has become known for many years as the finest system of health care in the entire world.

So what we are really fighting for here tonight is, not only the protection of patients, individual patients and their families, but we are fighting to preserve the finest quality system of health care the world has ever known. We need the stability in health care that this legislation will provide.

Now, the big debate is over this issue of accountability. Should a managed care company be accountable for their decisions? Well, frankly, I think that the answer is pretty obvious. Certainly they should be accountable. All of us are accountable for our decisions. All

of us can end up in court if we are negligent or make a mistake.

Frankly, the rule really is pretty simple, I think, that should be applied in this debate; and that is, when health insurance companies make medical decisions, they should be accountable in the same way that one's doctor is accountable when he makes a health care decision. We all know in this country that, if a doctor happens to make a mistake in the operating room, happens to do something that causes injury to one or one's children, that one can go to the courthouse and seek redress, seek recovery of injuries. A child who is paralyzed for life because of a mistake of a medical provider, that family can go to court, be compensated in damages. That is what our American system of legal justice guaranties all of us.

If a managed care company makes a decision that denies one health care when it is covered under the plan, now if it is not covered, it is just not covered and it is not going to be paid for, but if it is covered and, in their review of medical necessity they say one does not need that care, one's doctor is standing there all the while saying, yes, my patient needs that care, and the managed care company says, no, and one goes under the Norwood-Dingell bill and appeals that internally, and one appeals that externally, and one has got a decision, and one finds out that still the decision of the managed care company was wrong, every American ought to have the right to go to the courthouse and seek their damages. That is what the American system of justice is all about.

So if a doctor makes a mistake, he knows he has to go to the courthouse or could go to the courthouse. That is why he buys malpractice insurance. What is wrong with asking managed care companies to also carry malpractice insurance? Every profession in the United States, every individual who is a doctor, a lawyer, an engineer carries malpractice insurance. It is a wonderful thing, insurance. We spread the risk of loss among all of us to protect each of us individually.

Why should we in this hallowed hall of the House of Representatives declare this week that the only group in America that can never be held accountable in a court of law is a managed care insurance company? That is wrong, and we cannot let that happen.

I think we have a good bill. It ensures accountability, and it is drafted in a fair way. The only way one can go to court and sue a managed care company under this legislation is after one has gone through the internal and the external review procedure.

In Texas, the sky has not fallen. In Texas, we have the right to go to the courthouse. As the gentleman from Texas (Mr. GREEN) pointed out, there has only been a handful of lawsuits. In fact, there has only been five filed in Texas.

The author of the legislation that did pass in 1997, Senator David Sibley, a

Republican, good friend of mine, carried that bill. He says, and I quote, "The sky did not fall. Those horror stories raised by the industry just did not transpire." Dave Sibley, the sponsor of the bill is a lawyer, former doctor, an ally of Governor Bush.

Even Governor Bush acknowledged in the Washington Post September of this year that he believes the law in Texas has worked well.

I believe every American deserves the protection that we fought to give Texans in 1997. This legislation is long overdue.

I appreciate so very much the gentleman from Texas (Mr. GREEN) reserving this hour to give us the opportunity to talk about this important bill.

I believe the American people want this legislation. I believe the employers of this country who believe in protecting their employees want this legislation. I believe we need to ensure the long-term stability of the best health care system the world has ever known, and this bill moves us along the road in ensuring that.

□ 2100

Mr. GREEN of Texas. I thank my colleague. Again, having served with the gentleman both in the State legislature, the Senate and the House, and now in the Congress, we have gotten to that point. Because as Texans we brag all the time about how great our State is, and sometimes we puff it up a little bit; but we are not puffing on this legislation. This has worked in Texas, it has provided the benefits, all the accountability, the outside appeals process, the anti-gag orders so doctors can actually talk to their patients; and it has allowed patients to go to the closest emergency room without having to drive by closer emergency rooms.

So there are so many things I am proud of. Always proud to be a Texan, but particularly because of this legislation.

Mr. Speaker, I now want to yield to another good friend who I serve with on the Committee on Education and the Workforce. And I might just mention that her State, California, just recently passed a series of bills just similar to this, and I know Governor Davis signed them into law about a week ago.

I yield to the gentlewoman from California (Ms. WOOLSEY).

Ms. WOOLSEY. Mr. Speaker, I thank the gentleman from Texas and would like to compliment him for sharing with us tonight the experience of Texas in health maintenance organization reform. It is particularly appropriate that we are here tonight, because tomorrow, after fighting for more than 2 years, the House actually has a real shot at passing a managed care reform bill. The American people want this. In fact, they are demanding that we pass managed care reform, and I am particularly glad that this House is finally rising to the occasion.

I am also pleased that the Democrats and Republicans have worked together

to support a common sense patient protection bill. It is bipartisan. It is called, in fact, the bipartisan Dingell-Norwood bill. And any of my colleagues who are saying the Dingell-Norwood bill will not work are very, very wrong; and they have to review what has gone on in Texas. If they will pay attention to the Texas experience, they will know that the sky will not fall if we take care of patients when they are covered by a health maintenance organization.

I would like to share also some of the recent accomplishments from my State, the State of California, where just last week Governor Gray Davis signed landmark legislation that put health decisions back in the hands of 20 million patients and their doctors. This comprehensive package is made up of 19 bills, and it will absolutely overhaul the way HMOs do business in California.

A key piece in the package includes managed care accountability. The State now has a new Department of Managed Care, which will act as a watchdog for patients with HMO providers. This State agency is devoted exclusively to the licensing and regulation of health plans. The legislation will also include a new Office of Patient Advocate, which will assist in enrollees with complaints, provide education guidelines, issue annual reports, and make recommendations on consumer issues.

With this legislation, Californians now have the right to an external review of their health care coverage decisions by an independent group of medical experts. By January 1, 2001, this external review program will dispute claims when a patient's treatment has been delayed, denied, or modified.

I am proud to tell my colleagues that the package also includes HMO liability, giving Californians the right to sue their HMO for harm caused by failure to provide appropriate and/or necessary care. This is a much-needed remedy for any family harmed by a decision made by the HMO or by a clerk working for the HMO. Any decision that would delay, deny, or modify medically necessary treatment will be under scrutiny.

In addition, Californians can look forward, under this legislation, to new consumer protections. These protections will include a second medical opinion, upon request for patients; expanded patient privacy rights will prohibit the release of mental health information, unless patient notice is provided; and a prohibition on the selling, sharing or use of medical information for any purpose not necessary to provide health care services.

This legislation in California sets procedures for HMOs to review a treatment request by a doctor to ensure that timely information and decisions regarding a patient's treatment needs come forward at the right time. Patients will be informed of the process used by a doctor when that doctor de-

termines whether to deny, modify, or approve health care services.

In fact, Californians are also guaranteed the right to hold an HMO accountable by seeking punitive damages in court if and when harm comes to a patient. Congress should take note that if California can do it, and if California can pass similar reforms as those in the Dingell-Norwood bill, then, for Heaven's sake, we can pass the same type of legislation for our country. Because California has the population and the economy of a country in and of itself. California has 33 million people, and the challenge has been met.

Tomorrow, the Dingell-Norwood bill is a good starting point for the managed care reform we need in this Nation. The Norwood-Dingell bill provides Americans the ability to choose their own doctor, to get emergency room care, to see a specialist, and unleash their doctor from HMO gag rules on treatment options. And especially important for Americans is that the Dingell-Norwood bill holds HMOs accountable.

This bill has bipartisan support as well as support from more than 300 health care and consumer groups. I am convinced that this bipartisan bill deserves a clean up or down vote. It does not need to have any amendments.

The American people are counting on us to take heed of the Texas and the California accomplishments in HMO reform, so let us focus tomorrow on the consensus we have built. Let us accept no substitutes to the vital patient protections in the Dingell-Norwood bill, and let us again pay attention to what other States have been able to accomplish, such as Texas.

We are going to hear from Wisconsin and North Carolina, and we will see that the people in this country are telling us that they want and they demand health care reform and managed care reform, and we must heed this and go forward tomorrow.

Again, Mr. Speaker, I thank the gentleman from Texas for having this special order tonight.

Mr. GREEN of Texas. I thank my colleague from California. It is great to serve with the gentlewoman on the Committee on Education and the Workforce.

And the gentlewoman is right. In the California experience, it is both rural and urban. Just like Texas is rural and urban. So it will be a great example of making it work in this country from one coast to the other coast. We need to make sure that we have real patient care and managed care reform.

I would like to now yield to my colleague, the gentlewoman from North Carolina (Mrs. CLAYTON), who came in the same class as I did, in 1993.

Mrs. CLAYTON. Mr. Speaker, I thank the gentleman for yielding to me and arranging for this special order for us to talk about the provision in the bipartisan managed care reform bill known as the Dingell-Norwood bill. I am pleased to have this opportunity to

discuss it before we debate it on the floor tomorrow.

I am proud to be one of the original cosponsors of the bill and to be an advocate for it. I also serve as the co-chair of a health task force. And as an individual coming from a rural area, where a lot of our patients are still uninsured, I can also be a very strong advocate for this bill, which gives protection for managed care.

We have just heard recently that, indeed, the uninsured have increased. And I am concerned about that because many of the people in my district are indeed part of that uninsured. So my support for the Norwood-Dingell bill does not diminish my advocacy for making sure that we find ways of insuring more of the uninsured. Indeed, it was almost predictable, because we did not do what we could have done earlier when we had the opportunity to look at health care reform that, indeed, this rise would occur. I think we have an opportunity to speak to that, but I do not think one negates the other. So as one who is an advocate for making sure the uninsured are also protected, I strongly advocate the provisions of the bipartisan bill.

This bipartisan bill gives increased access to patients in a variety of areas. It says first that those who have emergencies should not have to have prior approval. They have immediate access for emergency treatment, even at the emergency hospitals of their choice. They should not have to be shifted around to various hospitals in that area.

It also increases the protections for women who want to be protected under this bill. It increases that access. It also increases access for those patients who have special needs and need to have specialty providers in treating their conditions. So the access is enhanced for those who have a managed care program.

Let me just say parenthetically that there are, indeed, good managed care programs. This is not to negate where there are positive managed care programs. This is to improve and to give some minimal standards that the managed care programs that people have should be dependable, they should be held accountable for their care, and they should be aware of defining medical necessity. All of these are to ensure that whatever plans we have, they should be the kind of plans that patients can have confidence in.

I cannot understand why it is that people are afraid of being held accountable. If they say they are going to provide certain services, they should be honored to say that they will be held accountable for those services. Indeed, being held accountable allows a review process. And if in the review process arbitration does not work out, the patient has the right to go to court. They have that opportunity.

Also, the bill protects the provider. And this is very, very important, because many doctors have said they

have been under a gag rule. They cannot tell their patient all of the options that they know would be good for their health care. So they are prevented from telling them options that would perhaps provide the right medical treatment because it is not the most economical treatment in that area. The anti-gag provision in this bill prevents that. It means that we protect the providers and we assure the confidentiality and the professional care between a doctor and their patient. And the patient also has a right in the selection of the provider that is adequately trained in those areas.

All of these provisions go to making the managed care program stronger for patients who have to have these insurance provisions. So I want to say to our colleagues that as we debate this bill tomorrow, that any options or amendments or substitutes that are being offered, and offered in glorious terms as being a cure-all for health care, are, indeed, poison pills. And if we are ensuring that patients have good health care, we have to vote down each and every one of those substitutes as well as those amendments.

So I urge my colleagues to give Americans a choice and, indeed, to give them a clean bipartisan Patients' Bill of Rights. And I thank the gentleman once again.

Mr. GREEN of Texas. Mr. Speaker, I thank the gentlewoman, and I want her to know that I am aware of the devastation in the gentlewoman's district, we talked about it today, from the hurricane. In Texas, we are familiar with hurricanes damaging our coast.

I would like to now yield, Mr. Speaker, to a new Member, a very active new Member from Wisconsin. And like I said earlier, we have people from not only the West Coast in California but North Carolina, on the East Coast, and of course in Texas, and also now the gentlewoman from Wisconsin (Ms. BALDWIN), and I yield to her.

Ms. BALDWIN. Mr. Speaker, I thank the gentleman for organizing this special order.

Time and time again we hear how the United States has the best health care in the world, but that does not matter if a health plan denies meaningful access to the health care system when individuals are sick. Managed care was designed to provide the best health care available at a lower cost. But what does it matter if in addition to our health insurance premium we still have to pay sizable, sometimes enormous out-of-pocket costs for needed tests or treatments that our health plan will not cover.

□ 2115

There was a time when we paid our health insurance premiums trusting that when we got sick our doctors would make his or her recommendations for treatment and that our health insurance would pay for that treatment. This just does not seem to be the case any more. We no longer trust that

the best medical decisions are being made in this system, and too many people with health care coverage are being driven into debt because necessary treatment is not being covered by their managed care company.

As my colleagues know, families in my community in Wisconsin feel very anxious about the state of health care in America. They are increasingly concerned that medical decisions are being made by accountants, by managers, by other insurance company employees instead of the doctors and the patients making the decisions; and too often profit is taking a priority over a sick patient in need.

Patients are losing faith that they can count on their health insurance plans to provide the care that they were promised when they enrolled and faithfully paid their premiums.

We have all read the stories, and those of us who have the privilege of serving here have often heard painful firsthand accounts from families and individuals who sent us here to fight for them, to represent them, people who were denied care or services by managed care providers.

I recall reading an article last winter in Wisconsin about a young man struggling with known Hodgkin's lymphoma. He was told by his doctor that the most promising and potential cure, a bone marrow transplant, was not going to be covered by his plan. Chemotherapy in his case would only slow down the disease. The prognosis they gave him was up to 10 years to live, and according to this prognosis 5 of those years his cancer with chemotherapy would likely to be in some sort of remission. However it would likely come back sometime within the second 5 years and get steadily worse. He underwent a round of chemotherapy because that is what his insurance company would cover. In his case his earlier prognosis was not accurate. It did not even give him 5 years of remission. Instead the cancer re-appeared in only 8 months.

Now this was a highly publicized case in my State, and because of the negative publicity and the public outcry, his insurance company relented and permitted the bone marrow transplant admitting belatedly. According to the medical literature, this was not a treatment that was regarded in the medical literature as experimental. Unfortunately, it was too late for this 41-year-old young man, and he passed away earlier this year.

But people should not have to wage publicity campaigns to shame their health care plans into covering medically necessary procedures. They should have appeals processes, not publicity campaigns.

I was deeply disturbed when I heard of another poignant case in my district. This is a story of a man who is in the hospital. He was recovering from a procedure, and he received a phone call from the representative of his HMO in his room saying that if he stayed in the

hospital room past midnight, his insurance company was not going to cover it.

Now this gentleman had just gotten out of intensive care, and it was all he could do practically to reach over and pick up the phone, and I just think how frightening this experience must be for the patient, for the family and for those who hear of it and wonder whether their insurance, their health care plans, their managed care plans are really going to cover them.

As my colleagues know, having a recourse when something goes wrong is so vital, and health plans should not be allowed to escape responsibility for their actions when their decisions kill or injure patients.

Six years ago we were promised reform that would guarantee every American the health care they needed. That vision was not realized. In this time of economic prosperity, in this time of rapidly changing medicine, in this time of political opportunity, I think it is time that we renew our commitment to the health care security for all; and when I think about what that means, I believe that health care security for all encompasses both the notion that we must cover the uninsured and the effort to fully protect those who already have health care coverage but find that is not the security blanket that they thought they had purchased.

Many States have taken steps to establish some of these patient protections. We heard about Texas and California earlier this hour. Unfortunately, most States have only passed a few of the protections contained in this bill before us, and there are many gaps that remain to be filled. Even States with strong consumer protection laws cannot cover a large number of their residents, the 50 million Americans who receive their insurance from a self-insured employer plan under ERISA and are not protected under State law.

We need comprehensive Federal legislation that provides a minimum standard of patient protections for all Americans. The Norwood-Dingell bill will do just that, and I hope tomorrow that this Congress rises to the occasion to pass this vital legislation.

Mr. GREEN of Texas. Mr. Speaker, I appreciate our colleague from Wisconsin in being here this evening and joining in this. We only have a few minutes left before our colleague from Iowa (Mr. GANSKE) comes to the floor. Having watched Dr. GANSKE over the last number of weeks and sitting in my office, returning phone calls, thank goodness an hour earlier in Texas, and I can catch up on that, and his efforts on managed care reform and his efforts over the last, in the last session of Congress.

Let me talk before we close about some of the bills or the competitive bills tomorrow to the Norwood-Dingell bill. There will be a bill called the Comprehensive Access and Responsibility Act introduced by the gentleman

from Ohio (Mr. BOEHNER). Which is one of the two alternatives. It falls very far short of the Norwood-Dingell bill and the protections that are in there. The biggest problem is it does not cover as many Americans as the Norwood-Dingell bill. It is very limited. Moreover, the bill has no provision to hold HMOs accountable for the decisions that harm their customers that are enrollees, and every other business in America is subject to liability for poor judgment, and why should not the health plans be any different?

Finally, this bill does not allow chronically ill patients to designate their specialist as a primary care provider. As our colleague from Wisconsin mentioned, there are times that you might need if it is an oncologist, if you have a cancer, if you have some other type of illness, you might want to designate that specialist as your primary care person, and that is in the Norwood-Dingell bill.

The other alternative by a couple Members of Congress, the gentleman from Oklahoma (Mr. COBURN), the gentleman from Arizona (Mr. SHADEGG), it is called the Health Care Quality and Choice Act. Now again for most folks who watch Congress and they understand that there is no requirement that the actual title of the bill reflect what is in the body of the bill, and we do not have any truth in titling here in Congress, because their bill again falls short. It would force patients harmed by their HMOs to go to Federal court so you can get behind all the Federal cases, and in Texas most of the Federal cases are drug cases, and they have preference; criminal cases have preference. So their bill would require you to go to Federal court.

First, the Federal system is much more difficult and expensive to access than State courts, and there are fewer of them, so patients will be forced to travel long distances, and particularly in rural areas, but even in Houston we have many more State courts in Harris County, Texas, than we ever have Federal courts. And worse yet, Federal law gives that priority to criminal cases over civil cases. So, in other words, maybe a decision will be made on whether you should have that bone marrow transplant. By the time you get to Federal court after all the other criminal cases are there, it may be 5 or 6 years later, and health care delayed is health care denied.

The Dingell-Norwood consensus bill is the only bipartisan bill that we have that recognizes medical necessity, that allows the patient and the doctor to define medical necessity based on the medical history and the specific need of that patient.

Appeals process. Again, modeled after the Texas law, allows patients to appeal the decision of their HMO to an independent external panel of specialists.

Access to specialists. As I said earlier, the bill requires health care plans to include access to specialists and

offer access to specialists that the patient needs.

Emergency room coverage. The bill provides guaranteed access to emergency services to managed care enrollees and requires a plan to pay for those services if a prudent lay person believes that they are in a health, in a life-threatening situation, and I use the example: I am a lay person. I do not know if I am having chest pains because of the pizza I had last night or it is because I am actually having a heart attack. I should not have to make that decision. That is why we need to go to the closest emergency room.

But the most important and the final issue is accountability. The reason the appeals process in Texas works is because ultimately they could go to court, and it is also the most controversial; but again this is modeled after the Texas law, and we have over 2 years experience. This bill allows Americans harmed by their HMOs to seek redress in the State court. However, to prevent frivolous cases, they can only sue after they have exhausted their appeals and the patient is harmed. The provision is tightly crafted so not only to hold the medical decision maker accountable.

And let me say in brief I had, a couple of years ago I had the opportunity to speak to the Harris County Medical Society, and after talking about some of the bills I have been working on, the first question from a doctor was, and by the way, I joked about my daughter having 2 weeks in medical school, and she was not quite ready to do brain surgery. The first question from that doctor to me said, you know your daughter after 2 weeks in medical school has more training than the person I call to treat my patients.

That is what is wrong with our medical system we have now. We do have the greatest health care system in the world. People come from all over the world to get to us to have that system, but we are denying it to some of our folks who have insurance, and we need to change that. We need to make sure that we restore that health care provider and that doctor so they can talk to their patient.

The reason, reasons the consensus bill are so insistent on accountability provision, because if you do not have that, you will not have, they will not have the incentive to change their practices, and while opponents of the strong binding consensus bill claim it would dramatically increase health costs, we know in Texas it has not increased health costs in 2 years; and what we found in Texas, that patients are right and about half their appeals in the health care plans honor that decision because they do not want to get sued. All the people want is their health care. They do not want to have to go to court; they do not want to have to go to State court, much less Federal court that is in some of the alternatives.

I would hope that my colleagues tomorrow would reject the poison pill

amendments. Sure we need to do additional access, and I would hope we can do that on the floor of the House sometime but without trying to dirty up the waters on providing access in modernization of the HMO process.

I have had my colleagues talk about earlier that all we are asking for is some guidelines for managed care to deal with their customers and our constituents and the doctors' patients. In fact, over the past 5 years all 50 States have passed laws to protect patients in State-regulated plans. Some of them are stronger than others, and these alternative bills essentially disregard the advances that are made in each State and moreover more people into Federal regulation would lose protections.

These laws have been passed by Democratic and Republican legislators. They have been signed into law by Democratic and Republican governors. But the Republican leadership would jeopardize the health care of millions in these protections unless we pass it tomorrow.

Mr. Speaker, I again thank my colleagues who were here tonight and all those who are listening because tomorrow, Wednesday, and Thursday this week this House will make some major decisions; and if we make the wrong decision like we did last year, then we will continue to have people denied adequate health care in our country. Our country is too great to do that.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, Will enactment of the Norwood-Dingell Bill lead to skyrocketing health care costs?

Since Texas began to implement a series of managed care reforms in 1995, our HMO premium increases have mirrored or trailed those premium hikes in other states that don't have managed care reform bills in place.

Nationally, health care costs have increased by 3.7 percent in 1998 while in Texas, the costs increased by only 1.10 percent for the same period.

Will enactment of the Norwood-Dingell Bill lead to frivolous law suits?

Since Texas enacted its Patient's Bill of Rights in 1997, there have been only five lawsuits in a managed care system that serves four million patients.

This number of lawsuits is low because our patients are fully using the external review process that is a component of the Norwood-Dingell bill. More than 700 patients have used the external review process in the past two years to appeal the decisions made by health plans. Of those, about half of the decisions have gone in favor of the HMOs.

Will the Norwood-Dingell Bill result in employers dropping their employees from health care coverage and thus drive up the number of uninsured families?

It may be too early to tell using our state's example. But the fact remains that as HMOs have increased penetration in recent years, so has the number of uninsured. That is the case in Texas and around the nation.

Since the Texas Legislature made managed-care plans liable for malpractice, there have been five known lawsuits from among the 4 million Texans who belong to HMOs.

"The sky didn't fall," said Sen. David Sibley, the Republican who championed the Texas

version of the Patient's Bill of Rights. "Those horror stories," envisioned by the health insurance industry "just did not transpire."

While it is too early to see the full effect on my state it is evident that the implementation of this legislation has had a dramatic effect on resolving complaints between patients and their health plans—before they get to the courthouse.

Clearly this legislation has acted as a prime motivator for HMOs to settle their disputes with their patients. Regrettably, the vast majority of Americans do not have this option. That's why it is vital that we have national Patient's Bill of Rights that has some teeth in it—that permits patients to sue their HMOs when treatment decisions result in injury or death as well as granting patients access to emergency care and specialty care that is not currently allowed.

I strongly believe that the Texas experience strongly speaks to the benefits of empowering patients and doctors so that they can work with the insurance companies in ensuring that our health care system provides the best care for all Americans.

Republican Health Care Bill:

The Republicans introduced the Quality Care for the Uninsured Act. This legislation does move the health care debate forward. But not very far. It is not a bipartisan bill and it does not address that entire scope of health care delivery or what's wrong with managed care.

At best the Republican bill nibbles around the corners of health care debate. It provides for Medical Savings Plans and 100 percent deductibility of individual insurance premiums for the self-insured and uninsured.

This legislation does nothing to increase access to emergency services or ob-gyn. It does nothing to address the lopsided nature of the managed care equation in which insurance companies make most of the patient decisions, while doctors and the patients themselves are left in the waiting room.

BI-PARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT (H.R. 2723)

H.R. 2723 that has already been introduced by Representatives CHARLES NORWOOD and JOHN DINGELL truly addresses the consumer and provider issues that have undermined the health care in America. I am a cosponsor of this legislation.

Its independent external appeals process will help patients get care quickly and resolve disputes without resorting to a court fight.

Once the appeals process has been exhausted patients will be able to hold health care plans accountable when they make negligent decisions that result in patient injury or death. At the same time, this legislation includes safeguards to protect employers from lawsuits and punitive damages against health plans that comply with the external review determination.

This legislation also provides patients with other essential protections including access to specialty care, emergency care, clinical trials and direct access to women's health services. Patients who need to go out-of-network for care will have access to a point-of-service option.

I look forward to a fair debate between our bi-partisan Patient's Bill of Rights versus the Republican Leadership's alternative. Once the American people fully understand what's in each bill—I am confident that the bi-partisan bill will prevail.

The majority of Americans would rather have a strong say in how they receive medical treatment than nibbling at the edges of this important problem.

Support and protect the Norwood-Dingell Bill; it's the only way to put doctors, nurses, and patients back into the business of patient care.

Mr. SANDLIN. Mr. Speaker, the Lone Star State has been a leader in health insurance reform. The Texas Legislature enacted a law in 1997 which protects patients' rights when insurance companies stand in the way of common sense and good medicine.

So what has happened in my home state over the past two years? Have our courts been overrun with frivolous lawsuits? Are families saddled with growing premiums? Are HMOs being run out of business? No. Not by a Texas mile.

Last week the Washington Post noted that only five lawsuits have been filed against health plans in Texas. That's five lawsuits in two years. Of the roughly six hundred complaints submitted to the independent review system established under the Texas law, about half of the cases have been resolved in favor of the patients, half in favor of the insurance companies. And premiums have not increased in our state. In fact, we enjoy some of the lowest premiums in the country. Almost everything is big in Texas.

And now the Lone Star State is not alone. California and Georgia have enacted health care legislation that will enable policyholders to sue their HMOs. And the majority of members of this body favor similar bi-partisan legislation.

Mr. Speaker, the question is no longer whether such provisions are a good idea, or even whether they are supported by legislators across the land and here in Washington. The question now is whether or not we, the House, will even have a chance to consider this measure. It will take, from the Republican leadership, the courage to stand up to big insurance companies and their scare tactics. And, I think, it will take an ounce of good old Texas courage.

GENERAL LEAVE

Mr. GREEN of Texas. Mr. Speaker, I ask unanimous consent that all Members be permitted to extend their remarks and include their extraneous material on the subject of this special order speech that I and my colleagues have given tonight.

The SPEAKER pro tempore (Mr. TOOMEY). Is there objection to the request of the gentleman from Texas?

There was no objection.

WHILE COVERING UNINSURED, LET'S FIX MANAGED CARE

(By U.S. Rep. Gene Green)

As the Congress prepared to debate several HMO reform bills this week, House Speaker Dennis Hastert, R-Ill., has stated his intention to include in the managed-care reform debate, health-care-related tax cuts. These incentives, called the "access package," are intended to allow tax cuts to the 44 million uninsured Americans who cannot afford health-care coverage.

While it is important that everyone has access to affordable health care, the issue that Congress has been debating for several months and that we should resolve, is how to reform our current managed-care system. If we are truly concerned about the uninsured,

let's expand health-insurance access to them—insurance that will actually provide quality health care. Various managed-care proposals will be debated, but it is important to look beyond the titles to see what each proposal would do to really protect patients.

The fact is, 48 million Americans belong to self-funded health-insurance plans that offer very little protection for individuals from neglectful and wrongful decisions made by their insurance plans. Although some states—Texas, for instance—have passed laws that protect consumers from health-insurance malpractice, the protections enacted by states only affect insurance policies licensed by the state. We need a national set of guidelines for health-plan conduct.

The Dingell/Norwood consensus managed-care reform proposal is the only bipartisan bill that provides the necessary protections to revamp the current managed-care system. This bill, developed over weeks of negotiations, would provide every American in an HMO or managed-care plan the fundamental rights they need to ensure they receive quality health care. Its major provisions are:

Medical necessity: Allows the patient and the doctor to define medical necessity based on the medical history and specific needs of the patient.

Appeals process: Allows patients to appeal the decision of their HMO to an independent, external panel of specialists.

Access to specialists: Requires health plans that include access to specialists to offer access to the specialist that the patient needs.

Emergency room coverage: Provides guaranteed access to emergency services to managed-care enrollees and requires the plan to pay for those services if a "prudent layperson" believes they are in a life-threatening situation.

Accountability: Allows patients harmed by their HMO to hold their health plan accountable in state court.

While other bills claim to provide these same protections for patients, one look beyond their titles proves otherwise. The Comprehensive Access and Responsibility Act, introduced by Rep. John Boehner, R-Ohio, does not apply to all Americans. It only covers employer-sponsored health plans, and leaves out the most vulnerable insurance consumers—those who do not have an employer to negotiate for them. Moreover, this bill has no provision to hold HMOs accountable when their decision harms a patient.

The other alternative is sponsored by Rep. Tom Coburn, R-Okla., and Rep. John Shadegg, R-Ariz. This bill would force patients harmed by their HMO to seek remedies in federal court. The practical impact of this provision would be devastating to patients. First, the federal court system is much more difficult and expensive to access than state courts. There are fewer of them, so some patients could be forced to travel long distances. Worse yet, because federal law gives priority to criminal cases over civil cases, patients seeking remedies could be forced to wait years while the backlog of criminal cases clears. Finally, this bill does not allow chronically ill patients to designate their specialist as their primary-care provider. This means that every time they need to see their doctor, they have to go to another primary-care doctor first and get a referral.

Accountability and enforcement for medical decisions is the critical issue in the HMO debate. Without an effective accountability provision, managed-care companies will never have an incentive to change their practices of placing profits before patients. And while opponents of the strong and binding Norwood-Dingell bill claim it would dramatically increase health costs, we in Texas know it won't. The majority of the "expensive" provisions in the bill—which include

accountability, decisions of medical necessity and external appeals—were modeled after the Texas law. What we have found in Texas is that patients are right in about half of their appeals and health plans honor that decision. Since the law took effect, health-cost increases in Texas have been a reflection of rising prescription drug costs and inflation—just as we have seen in every other state.

It is our responsibility to ensure that patients get the high-quality health care they pay for and deserve. When Americans buy health insurance, they should not have to lose their relationship with their doctor or worry if their insurance plan will pay for the medical bill as they are heading to the emergency room. It is time that we provide patient-protection rights for consumers and for managed-care plans to be made accountable for delivering quality care and respecting basic consumer rights.

CONTINUATION OF DISCUSSION ON HEALTH CARE

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

Mr. GANSKE. Mr. Speaker, I appreciate the remarks of my colleagues from across the aisle as they relate to health care. I am going to continue the discussion on health care, and if my colleagues from Texas want to contribute to some of this, that would be just great; and I will be happy to recognize them periodically.

Let us talk a little bit about how people receive health care in this country.

So I have a chart here I want to share with my colleagues.

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Let us just assume that this square represents all of the health insurance market, and the circle represents, both red and white in the circle, employer-based health insurance. So that you have about two-thirds of employer-based health insurance, consisting of employers offering fully insured products, i.e., you have your small business that contracts with an HMO. About one-third of employer-based health insurance is what we call self-funded employer plans. Then you have, outside of the employer-based health insurance, you have health insurance that is provided by churches and certain non-profit organizations, Medicare, Medicaid, public sector employees, i.e., government employees, both Federal and State, and you have individuals who buy insurance policies.

Now, Congress passed a law related to pensions about 25 years ago called the Employee Retirement Income Security Act, and those people who receive insurance from their employer, those within the circle here, are under that law, the ERISA law.

Now, about two-thirds of those employer-based programs are under both Federal and State regulation. To some extent states regulate those plans, but the white area here is totally regulated by the Federal law.

The problem is in this area that frequently there are jurisdictional disputes between whether the State has the right to oversee those plans in some ways, or the Federal Government does, and that frequently ends you up in court fighting that out or with legal disputes. That needs to be clarified by Congress.

But one thing is pretty clear, and that is that there has been a universal feeling that if you are in an employer-based plan, both the red and the white in this circle, that then you are shielded from any responsibility, any legal responsibility, for bad actions that could result from the medical decisions that your health plan makes. The health plan is shielded from their negligent actions. That is something we need to address here in a few minutes.

Now, we are going to be debating in the next two days both a bill related to increasing the number of people in this country that are inside this square, i.e., those that have insurance, and we are going to be debating what quality of care those who are inside the circle receive.

Let me speak for a minute about those that are off the chart, the 44 million Americans that do not have health insurance.

This number has gone up steadily over the last several years. As a percentage of the number of people in this country, however, it is staying about the same, about 16.2 percent. In other words, the number of people in our country is increasing as well.

Who are those people who are not inside the box, that do not have health insurance? They are primarily the young, i.e., those between 18 and 24, and the poor, and there is a sizable percentage of them who qualify for Federal programs already, but they are not enrolled.

There are 11 million uninsured children in this country today. More than half of those children qualify for Federal programs to pay for their insurance, either through Medicaid or through what we call the children's health insurance plan, the CHIP program.

Why are they not enrolled if they are qualified? Frequently it is a matter that the parents do not even know about it, or the states and Federal Government have not done a very good job in making sure that people who qualify take advantage of those benefits. That would go a long way. If you could reduce the number of uninsured children in this country by 5 million simply by getting those children into the programs that already exist, you have made a big dent in the number of uninsured. We ought to do that.

We are going to be debating on the floor some tax measures, some measures related to changes in what are called association health plans; there will probably be some debate on medical savings accounts, some things like that.

Some of those areas I agree with; some I have some problems with. I am

worried that with the association health plan measure in the access bill that it could have unintended consequences to actually increase the cost of insurance for those who are, for instance, in the individual market, the individual health insurance market. Nevertheless, we are going to have a debate on that. I anticipate there will be some support for that bill from both sides of the aisle. Then we are going to have a debate on how to improve the health care for those people in this country who are already spending a lot of money on health care.

But while I have this chart up here, I think it is useful to point out something, because there was a recent study by the Kaiser Family Foundation on the relative cost of lawsuits in comparing those people who are in the ERISA plans who are shielded, whose plans are shielded from liability, to those that are in non-ERISA plans where you can obtain legal redress against your HMO if they commit an injury to you or your loved one.

Remember this: Government employees are in non-ERISA plans. That means that government employees have a right to sue their HMO. But if you receive your health insurance from your employer, either through an employer offering fully insured products, like HMOs or self-funded products, you do not.

So this is a good comparison, the comparison on premiums and on the incidence of lawsuits between those that can sue, i.e., churches, people in churches or public sector employees or individuals, versus those that cannot.

The Kaiser Family Foundation found out that the incidence of lawsuits in those who are in plans where you can sue is very low, and that the cost, the estimated cost for providing that right to those who do not have it, would be in the range of 3 to 12 cents per month per employee. That is a rather modest cost when you think about how that could prevent something truly awful.

Let me describe a case that is truly awful. We have here a little boy, a beautiful little boy about 6 months old, and he is tugging on his sister's sleeve. His name is James.

Sometime shortly after this picture was taken he became sick. At about 3 in the morning he had a temperature of 104 or 105, and his mother, Lamona, looked at him and she knew he needed to go to the emergency room because he was really sick. So she phones her HMO on a 1-800 number and says, "My little boy is really sick and needs to go to the emergency room." Some disembodied voice over a 1-800 telephone line who has never seen Jimmy Adams says, "Well, I guess I could let you go, but I am only going to authorize you to go to one hospital that we have a contract with." The mother says, "That is fine, where is it?" The medical reviewer says, "I don't know. Find a map."

Well, it turns out it is a long ways away, 70-some miles away, and you