by a health plan towards physicians who advocate on behalf of their patients within the health plan, or before an external review entity. Family physicians, as primary care physicians, play a pivotal role in ensuring that their patients get access to the care they need. Health plans should not have the power to threaten or retaliate against physicians they contract with to provide needed health care services.

Independent external review standards must be truly independent. Managed care reform must contain a fair, independent standard of external review by an outside entity. It makes no sense to pay an outside reviewer to use the same standard of care used by some health plans which may limit care to the lowest cost option that does not endanger the life of the patient. All of our patients deserve better.

Patients need the right to seek enforcement of external review decisions in court. Managed care reform must allow patients to seek enforcement of an independent external review entity decision against the health plan. Without explicit recourse to the courts, the protections of external review are meaningless.

Patients need access to primary care physicians and other specialists. Managed care reform must allow patients to seek care from the appropriate specialist, including both family physician and obstetricians/gynecologists for women's health, as well as both family physicians and pediatricians for children's health. Primary care physicians should provide acute care and preventive care for the entire person, and other specialists should provide ongoing care for conditions or disease.

And so you see, Mr. Speaker, from patient to physician, from consumer to provider, those who want serious reform and serious change know that the Dingell-Norwood bill is the way to go.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Under a previous order of the House, the gentleman from Oklahoma (Mr. ISTOOK) is recognized for 5 minutes.

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

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

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

TWO EXTREMES IN THE HEALTH CARE REFORM DEBATE

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

Mr. SHADEGG. Mr. Speaker, I want to begin by thanking my colleague, the gentleman from Illinois (Mr. DAVIS). He read a letter from a doctor, a constituent of his, who said that he supported two bills, and I think it is very important to note that of the two numbers he read off, the second number that the doctor wrote him about said he supported H.R. 2824.

I think the doctor is right about that. H.R. 2824 is the Coburn-Shadegg bill, the bill that I have cosponsored, and his medical doctor constituent wrote to him to say that he favored either the Norwood-Dingell bill or the Coburn-Shadegg bill. I hope tomorrow the gentleman from Illinois (Mr. DAVIS) will cross the line and do exactly what that doctor said, support the Coburn-Shadegg bill, because it is a reasonable alternative.

I want to talk for a moment about the two extremes in this important health care debate. One extreme says we should do nothing about the faults in the Employee Retirement Income Security Act. One of our colleagues, the gentleman from Mississippi (Mr. PICKERING), his father is a district judge. He has written a number of opinions in this area. I want to quote from those.

I sent around a series of dear colleagues: ''ERISA abuses people. Courts cry out for reform.'' Here is what Judge Pickering wrote: ''It is indeed an anomaly that an act passed for the security of the employees should be used almost exclusively to defeat their security, and to leave them without remedies for fraud and overreaching.''

Second in this series that I want to talk about, ''ERISA abuses people, courts cry out for reform,'' is a decision written by Judge William Young of the Federal District Court in Boston. He writes, ''It is extremely troubling that in the health insurance context, ERISA has evolved into a shield of immunity which thwarts the legitimate claims of the very people it is designed to protect.''

I want to conclude this series by again reading from another opinion by Judge Pickering in which he says, ''Every single case brought before this court has involved an insurance company using ERISA as a shield to prevent employees from having the legal redress and remedies they would have had under the longstanding State laws existing before the adoption of ERISA.''

Not amending ERISA is an extreme position that will hurt the American people. But I want to point out, there is another extreme position in this debate. That second extreme position is represented by the Norwood-Dingell bill.

The Norwood-Dingell bill is extreme in several regards. First and foremost, it does not protect employers from liability. I want plans held liable. I do not want Mrs. Corcoran's baby to be killed and the plan to be able to walk away, as happened in Corcoran versus United States Health Care. But when that plan is held liable, I do not want the employer held liable. The employer just hired the plan. The employer just wanted to offer health care to his or her employees.

The Coburn-Shadegg proposal, now joined by the gentleman from Florida (Mr. GOSS), the gentleman from Pennsylvania (Mr. GREENWOOD), and the gentleman from California (Mr. THOMAS) protects employers. Employers are not liable unless they directly participate in the final decision. That is the key language.

That means, and here is the debate, and Members will hear this from industry, an employer is not liable, cannot be sued, for merely selecting a plan or for merely deciding what coverage ought to be, or for selecting a third party administrator.

An employer cannot be held liable for selecting or continuing the maintenance of the plan. They cannot be held liable for modifying or terminating the plan. They cannot be held liable for the design of or coverage or the benefits to be included in the plan. They can only be held liable if they make the final decision to deny care. That is the way it should be.

I want to go on to point out that the other extreme position represented by Norwood-Dingell is lawsuits by anyone, as my colleague, the gentleman from California (Mr. THOMAS) pointed out, that let the jury decide injury. Our bill says no, you have to have a panel of doctors to decide injury.

Lawsuits at any time. They do not want you to have to go through internal and external review. They do not want to have to give the plan a chance to make the right decision. They want to just go to court.

Lawsuits over anything. Our legislation says it has to be a covered benefit. Their legislation says you can sue over anything, just get the lawyer and go to court. Their bill says lawsuits even when the plan does everything right. Our legislation says, no, if the plan makes the right decision, you should not be able to throw the book at them in court and drag them and blackmail them into making a settlement.

Their position is lawsuits without limits. They want all kinds of unlimited damages. There are over 100 organizations, not trial lawyers, but over 100 organizations endorsing the Goss-Coburn-Shadegg-Greenwood-Thomas proposal. I urge my colleagues to join us in passing this needed legislation.

A RULE WHICH MAKES PASSING GOOD MANAGED CARE REFORM DIFFICULT

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

Mr. PALLONE. Mr. Speaker, in this Republican Congress, the special interests who write the big checks get the last word. The day before the House

began its debate on the Patients' Bill of Rights, the only bill that takes medical decision-making away from insurance company bureaucrats and returns it to doctors and patients, the gentleman from Illinois (Speaker HASTERT) sat down with 15 health care lobbyists who paid $1,000 each for one last chance to make their case.

The health care industry has cultivated the Republican leadership with strong-armed lobbying efforts and well-placed campaign contributions, over $1 million from the Health Benefits Coalition, a group of insurance groups alone.

House Republicans, led by the majority whip, the gentleman from Texas (Mr. DELAY) and the gentleman from Illinois (Speaker HASTERT) are doing everything they can to kill reform to please their contributors in the health insurance industry. Mr. Speaker, that is why they put forward the rule today that was adopted on an almost exclusively partisan vote. Almost every or actually every Republican voted for the rule, and almost every Democrat except for one or a few voted against the rule.

Mr. Speaker, I just want to talk a little bit, if I can, about this rule and why it is making the ultimate question of passage of good managed care reform difficult.

The rule, instead of providing a fair and open rule for considering the Patients' Bill of Rights, basically stacks the deck by insisting on provisions that blend the managed care bill, the Patients' Bill of Rights, with a measure riddled with special interest poison pills designed to kill the Patients' Bill of Rights, the Norwood-Dingell bill, and that denies the gentleman from Michigan (Mr. DINGELL) and the gentleman from Georgia (Mr. NORWOOD) the opportunity to offset any potential revenue losses from the measure.

The Republican bill basically combines a so-called access bill, H.R. 990, and the managed care bill, the Norwood-Dingell bill, together. The measure will combine essentially a meaningful managed care bill with a special interest-laden boondoggle of a bill that masquerades as a health access bill.

There is no question that this rule which was adopted today, I would say again, on almost exclusively a partisan vote, is nothing more than a cynical, desperate, last-minute attempt to stave off a bipartisan Norwood-Dingell managed care bill that was on the verge of passage.

I am very fearful, Mr. Speaker, about what kind of success we are ultimately going to have here tomorrow with regard to the Norwood-Dingell bill because of the way that this rule provides for us to proceed, and because of the stark choices that many Members will have to make; had to make today on the so-called access bill, and will have to make tomorrow on some of the substitutes to Norwood-Dingell.

I wanted to talk about this phony access bill that was voted on today, again, almost exclusively on a bipartisan basis. Most of the Republicans voted for the access bill and most of the Democrats voted against it.

First of all, I would point out that it is designed, according to the Republican leadership, to try to improve access to health insurance for the over 40 million Americans that have no insurance, who are right now uninsured. But the phoniest aspect of this, if you will, is that the bill, this access bill, spends Federal dollars on tax breaks that do more to help the healthy and the wealthy than the uninsured.

According to the General Accounting Office, nearly one-third of all uninsured Americans do not pay income taxes. These families would not be helped at all under the bill that was passed today. Instead, the greatest benefits under the bill would go to the 600,000 uninsured families that make almost $100,000 per year, because the value of shielding income from Federal tax is greater for those in the highest tax bracket.

In addition to not helping the uninsured because so many of them essentially are not paying taxes, or are not paying that much to benefit from this bill, the bill expands medical savings accounts, a special tax break for the healthy and wealthy that threatens to increase health insurance premiums for everyone else.

My point is, Mr. Speaker, that the so-called access bill today, which the Republican leadership claims is trying to get more people into insurance plans and out of the ranks of the uninsured, in fact will make it more difficult for those who are uninsured to buy insurance because the costs will go up. That is accomplished, first of all, by putting in the poison pill of the medical savings accounts, the SMA's, as well as new Federal regulations that would disrupt State health insurance markets.

With the SMA's, and this is nothing new, this is something we have seen over and over again over the last couple years in an effort to try to defeat managed care reform, this poison pill, which was included in the 1996 bill, basically is a tax break for the wealthy.

The new Federal regulations that would disrupt State health insurance markets that are in this bill, the access bill, basically are two proposals called association health plans and HealthMarts, both of which would offer cheaper, less comprehensive policies that bypass State consumer protection, insurance, and benefit requirements.

Like medical savings accounts, these new plans and networks would be able to cherrypick the healthiest out of the State-regulated health insurance market, which could result in higher costs for those still in the State-regulated market.

In addition, like medical savings accounts, the association health plans are supported by big contributors to Republican candidates.

Mr. Speaker, my point is that this access, this so-called access bill that was adopted today, really is mucking up, if you will, the possibility of passing real managed care reform because it will travel now with whatever managed care reform bill that we adopt tomorrow and go over to the Senate together.

It means that whatever managed care reform bill we pass tomorrow will now have these other provisions attached to them, attached to it, that basically are going to make it more difficult to pass in the Senate, more difficult to adopt in conference, if the Senate and the House ever get together to try to come up with a bill that both houses adopt, and undoubtedly will result in a veto by the President, because he could not possibly sign provisions like the SMA's, like the HealthMarts, that basically break the insurance pool and make the costs to buy insurance for those who do not have it even more costly than it is today.

I would like to go on, though, and talk about what is going to happen tomorrow. The access bill is passed, the rule was passed. There is not much we can do about it tomorrow. But tomorrow we have more debate, which began tonight, on the Norwood-Dingell bill, and three substitutes that have been made in order under the rule which really, again, are nothing more than an effort to try to kill and water down the Norwood-Dingell bill.

I have said over and over again on the floor of this House and in this well that the two major advantages and overall goals, if you will, of the Norwood-Dingell bill are fairly simple, fairly easy for the average person to understand.

First of all, the first principle, the first goal of Norwood-Dingell, says that on the one hand, right now most decisions about what kind of medical care we get, what type of operation we get, or what kind of equipment we can use, or how long we stay in the hospital, or all the other things that define adequate health care, the decision as to what type of care we get is essentially now made by the HMO, by the insurance company.

That is not the way it should be. What should be and the way it used to be a few years ago was that the physician, the doctor, our doctor, and us, the patients, would determine what kind of care we were going to get.

We want to turn that around. In the Norwood-Dingell bill, we want to go back to the old days, essentially, when decisions about the type of care that we as Americans receive are basically decisions made by the physician, the doctor, and us, the patient.

The second thing we do in the Norwood-Dingell bill is to say that if we have been denied care that we and our physician think we should have had, then we have to have some adequate way to enforce our rights and overturn that denial of care. That is essentially done in two ways with the Norwood-Dingell bill.

First of all, there is an independent review, so that we do not have to go to

the HMO and appeal their decision, and essentially appeal to them or someone who is within the HMO to decide the appeal. Rather, we go to an external, independent review board not controlled by the HMO, which has the ability to overturn that decision and provide us with the care that our physician and we say we need in a very quick, expedited way.

Failing that, if for some reason this independent external review does not work and we are still denied care that we and the physician think we need, then we have the right to go to court and seek an action to overturn that denial of care. Or if the situation has resolved itself so that we were denied the care and we suffered damages, we were injured, we suffered, or God forbid, died, then we would be able to sue in the courts for damages as a result of that denial of care.

□ 2130

Now, all this makes perfect sense; and, frankly, I do not know what the big deal is. Any time people have a grievance and they suffer damages, they normally can go to some kind of review and take some kind of appeal and ultimately go to the courts.

What we are told by our colleagues who support the Republican leadership on the other side is that that is not acceptable. In fact, the previous speaker made the point that it is not acceptable; that the Norwood-Dingell bill goes too far in providing enforcement actions.

Well, let me just say, if I could, a few things about these substitutes that are going to be considered tomorrow and why they do not establish the two goals, they do not meet the two tests that I have already mentioned; and that is, who is going to decide what kind of care one gets; and, secondly, how one is going to enforce one's rights if one was denied care.

We have three substitutes that will be considered tomorrow. I just want to basically go through some of the key concerns I have with these substitutes and why I ask my colleagues to vote no against them and to let us have, instead, the Norwood-Dingell bill as the base bill that we are voting on.

Let me take first the Boehner amendment in the nature of a substitute. This bill does not include many important patient protections. Now, I have not spent the time this evening going into all the patient protections, all the specific patient protections that the Norwood-Dingell bill provides, and there are many. I have talked about them many times, so I am not going to go through them all this evening.

But I did want to talk about the patients' protections that are in the Norwood-Dingell bill that are not in the Boehner substitute. The Boehner substitute does not apply to all Americans in privately insured plans. It fails to extend protection to millions of Americans who purchase insurance individually.

Now, my colleagues have to understand that, in the other body, a managed care bill was passed in the Senate that basically covered very few people.

The tremendous advantage of the Norwood-Dingell bill is that it covers everybody, anybody who has insurance. Well, if my colleagues were to adopt the Boehner substitute tomorrow instead of the Norwood-Dingell bill, basically millions of Americans who purchase insurance individually would not be covered.

The Boehner substitute also does not include a provision on accountability or liability. It, therefore, provides no meaningful remedies at all for individuals in employer plans. It takes away current remedies by placing restrictions on all health care liability claims, including those in State court.

The bill also does not include access to specialists, an important aspect of the Norwood-Dingell bill, access to non-formulary drug, another important aspect in the Norwood-Dingell bill, protections for patient advocacy or limits on financial incentive arrangements that induce providers to withhold care.

One of the things that is most abusive today and one of the biggest criticisms that I receive from my constituents is that, right now, HMOs provide financial incentives to physicians not to provide care. That is an awful thing. But that is the reality today in the managed care system for many people.

The Boehner bill does not do anything to correct that, whereas the Norwood-Dingell bill does. The Boehner substitute's external appeals provision would require external reviews to use the plan's definition of medical necessity.

When I talked before about how the Norwood-Dingell bill, one of its two major goals is to make sure that the physician and the patient decide what kind of care one gets, that is because, in the Norwood-Dingell bill, the definition of medical necessity, what is medically necessary is made by physicians. It is a standard developed in the particular specialty by the doctors in that specialty area. So that, for example, for cardiology, the Board of Cardiologist standards would hold sway.

Well, the Boehner substitute basically says that, in doing an external review, the plan's definition, the HMO insurance company's definition of medical necessity holds sway. So there again, the HMO is going to decide what kind of care one gets. Reviews would only decide if the plan followed its own guidelines, essentially rubber stamping the HMOs decisions.

The Boehner bill also says that plans control, HMOs control what information patients have to submit to the reviewers. The patient does not have the right to submit his or her own evidence. There is no requirement that reviews be made in accordance with the patient's medical exigencies. A review panel could take up to 30 days.

Again, the problem with these substitutes to the Norwood-Dingell bill is that, if one has been denied care, one is not going to be able to have an effective appeal in a timely manner. That is one of the biggest problems with the Boehner substitute.

Now, let me talk about the Coburn-Shadegg-Thomas substitute. The gentleman from Arizona (Mr. SHADEGG), just a few minutes before I spoke, talked about how wonderful this substitute was. I would point out that the Coburn-Shadegg-Thomas substitute, the second substitute that will be considered tomorrow in lieu of Norwood-Dingell falls short on many important patient protections.

There is a $100 threshold to get to external review. A person who is denied a simple, yet life-saving, test would never get the review. There is no ability for patients to get access to off-formulary drugs when necessary.

The Coburn-Shadegg bill only requires coverage of routine costs of cancer trials, leaving patients with other devastating diseases without any protections. Emergency coverage under the Coburn-Shadegg bill for newborns is judged by a prudent health professional standard. That could mean that plans could deny payment for a larger range of neonatal emergency care.

But let me also talk about the enforcement aspects of the Coburn-Shadegg bill. Again, if one is denied care, how does one enforce one's right to overturn that denial and have the care provided? Well, under the Coburn-Shadegg substitute, there is an entirely new Federal cause of action.

HMOs can require an enrollee, a patient, to go to a certification panel that would decide whether the person was injured and whether this was caused by the HMO. If the panel finds for the HMO, the suit is dismissed.

The bill basically caps the amount of noneconomic damages a person can receive. It also undermines existing remedies because it requires that a person go through the bill's Federal remedy before seeking any State remedies.

What we are seeing here is a series of hoops. I have to be honest. I felt that the gentleman from Arizona (Mr. SHADEGG) was actually being somewhat honest when he was saying that there were major limits on one's ability to sue in the substitute that he has co-authored. Well, why should that be? Why are all these limits placed on one's ability to sue if one has seriously suffered damage? I mean, this is not right.

What we are trying to do here in the Norwood-Dingell bill is to basically make sure that one has a remedy, a right to enforce one's rights, and to make sure that one is not denied care. Any effort to basically water that down, to me, makes no sense and should be defeated.

Mr. Speaker, let me lastly talk about the third substitute that the House will consider tomorrow, and that is the Houghton substitute or Houghton amendment.

It strikes the liability provision from the Norwood-Dingell bill and replaces

it with a weak Federal remedy under ERISA. The Federal remedy would preempt a long history of allowing States to provide appropriate remedies for various harms suffered by their residents.

All we are doing in the Norwood-Dingell bill is saying that one has a right in State court or under State law to sue in the same way that one would for any other damage that one suffered.

Well, why should we go along with the Houghton amendment which basically strikes that liability provision in Norwood-Dingell and creates another Federal remedy under ERISA? ERISA is the Federal law that preempts the State law and then makes it so that, even in States like Texas or New Jersey, where we have patient protections on the State level, that one does not have any right to those protections because one's employer may be self-insured; and, therefore, one falls under the Federal ERISA law.

Well, the Houghton amendment would basically strike the provisions from Norwood-Dingell and give one another Federal ERISA remedy rather than being able to sue under State law. This Federal remedy under the Houghton amendment is full of loopholes and would allow plans, HMOs to escape liability.

The Houghton amendment provides bonding arbitration in place of external review and access to courts with minimal, if any, protections for consumers against bias.

Once again, Mr. Speaker, I urge my colleagues to look carefully at these substitutes tomorrow, and they will find that, in every case, they limit the ability of an American, of our constituents to be able to get quality care and to enforce their rights to make sure that they get their quality care. That is why all those substitutes should be defeated, and we should simply pass the Norwood-Dingell bill.

I wanted to mention a few other things tonight about some of the attacks that we are getting and that I am sure will intensify tomorrow against the Norwood-Dingell bill, which I think have been effectively refuted by those who support the Norwood-Dingell bill, but I want to mention them again because they continue unabated.

We are told, of course, the old thing, that the Norwood-Dingell bill, the Patients' Bill of Rights, is going to allow for numerous lawsuits, and that that is going to increase the costs of premiums, and ultimately employers will drop coverage for their employees because the costs will be too high.

Well, I think that that has been effectively refuted by the fact for the last 2 years that the State of Texas has had on its book a patient protection act very similar to the Norwood-Dingell bill. The reality is there have been only four lawsuits filed during that 2-year period in the State of Texas, and the cost of premiums have gone up less than they have in States that do not have those same kind of patient protections.

I do not think anything more needs to be said on the issue of costs or the issue of suing the HMO and liability and excessive lawsuits than to look at the Texas example.

But the other attack that we are getting again was made by the gentleman from Arizona (Mr. SHADEGG) earlier this evening when he said that the Norwood-Dingell bill would allow for employers to be sued; and because employers would be sued, they would drop coverage because they would not want to be the subject of lawsuits.

Well, again, that is not accurate. The Norwood-Dingell bill has very specific shield language that shields the employer from liability unless they are actually involved in the decision to deny one care.

I would say that even the gentleman from Arizona (Mr. SHADEGG) admitted that, if they are involved in a decision to deny one care, they should be sued.

The bottom line is that it is only the Norwood-Dingell bill that provides this kind of a shield to make sure that employers cannot be sued. To suggest somehow that that shield will not work again is inaccurate.

I just wanted to cite a reference that has been made again by some of my colleagues today and on other occasions, the myth that is being promulgated against Norwood-Dingell on this point is to say that employers would be subject to lawsuits simply because they offer health benefits to their employees under ERISA.

Well, section 302(a) of the Norwood-Dingell bill specifically precludes any cause of action against an employer or other plan sponsor unless the employer or plan sponsor exercises discretionary authority to make a decision on a claim for covered benefits that results in personal injury or wrongful death.

Now, how do we define exercise and discretionary authority? The myth again being promulgated by those against the Norwood-Dingell bill is that employers' decisions to provide health insurance for employees will be considered an exercise of discretionary authority. That is simply not true.

Examples of the types of decisions that health plan administrators make that directly affect the care that patients receive and could be considered medical decisions include inappropriately limiting access to physicians through restricted networks, refusing to cover or delay needed medical services, drawing treatment protocols too narrowly, offering payment incentives, or creating deterrence to discourage the provision of necessary care, and discouraging physicians from fully discussing health plan treatment options, the so-called gag rules. These are not decisions that employers make.

The Norwood-Dingell bill excludes from being construed as the exercise of discretionary authority decisions to, one, include or exclude from the health plan any specific benefit; two, any decision to provide extra contractual benefits; and, three, any decision not to consider the provision of the benefit while its internal or external review is being conducted.

So the bottom line is the employer is shielded from liability. That is the simple truth. That is why the Norwood-Dingell bill should be adopted tomorrow and not some of these substitutes that claim to improve on the law.

Now, let me just say one thing finally if I could, Mr. Speaker. It sounds kind of crazy, but I have heard some of my colleagues say, well, why do we need to pass the Norwood-Dingell bill? Why do we need Federal legislation to address the abuses of managed care, because, after all, the States are doing this, and even the courts are doing it?

I mentioned the Texas law. I mentioned the other day, and some of my colleagues have talked about it, California really recently enacting a law which was signed by Governor Davis just a few days ago.

We have also heard about court cases, a recent decision by the Illinois Supreme Court that ruled last Thursday that HMOs may be sued for medical malpractice.

Just last week as well, the Supreme Court assigned itself an important role in the debate over managed care, the U.S. Supreme Court, by accepting a case on whether an Illinois health maintenance organization breached a legal duty to a patient whose appendix burst during an 8-day wait for a test to diagnose her abdominal pain.

□ 2145

So some of my colleagues are saying to me, we have some States that are passing laws, let them continue to do so. Or we have the court, this case Illinois or maybe even the Supreme Court of the United States, that will ultimately say that an individual has the right to sue the HMO, so why do we need the Norwood-Dingell bill? Well, the fact that many States have decided that they cannot wait for Federal action and have passed these measures to strengthen patient protection should not be an excuse to not have Federal action.

The bottom line is, and if I could just read from an editorial that was in The New York Times the other day, it talks about why State laws are not sufficient, and it says and I quote, ''State initiatives do not replace the need for Federal legislation. For one thing, none of these State protections apply to people in self-insured plans created by large employers, which are exclusively federally regulated. More important, current Federal law has long been interpreted to bar patients covered by private employer-sponsored health plans from suing for damages caused by improper benefit denials, although the Supreme Court this week decided to hear a case that will review this issue. The California legislation tries to get around the legal hurdle by framing the new State-granted right to sue as based on the right to obtain quality care rather than the right to particular benefits. That approach will clearly be

challenged in court and may well be struck down unless Congress closes the loophole in Federal law that now shields health plans from meaningful liability.''

Mr. Speaker, if I am one of the people, one of my constituents out there who has been denied care, I can assure Members that it is not going to make me feel good that I do not come under the patient protections because I happen to be in an ERISA federally-preempted plan, or that I have to wait for the courts, whether it be Federal or State courts, to find a loophole so that I can sue the HMO.

Again, Mr. Speaker, I would say it has been an interesting debate today. I think it is very unfortunate that the rule passed. I think it is unfortunate that this access bill passed now, and that whatever we do pass tomorrow will have to be incorporated in this so-called access bill that I think provides a number of poison pills and will make it difficult for the Norwood-Dingell bill to move in the Senate or to be resolved in conference.

But I would still urge that tomorrow is also an important day, and we want to make sure that the Norwood-Dingell bill passes and is not superceded by some of these other three substitutes that basically will water down the protection and the enforcement rights for our constituents that exist in the Norwood-Dingell bill.

I urge my colleagues tomorrow to support the Norwood-Dingell bill and to vote ''no'' on all the substitutes.

ISSUES OF CONCERN

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

Mr. MCINNIS. Mr. Speaker, this evening I want to address really three subjects. The first two subjects will be quite brief.

One, satellite TV. Many of my colleagues, who like me represent rural districts in this country, have a deep concern about the reception and the need for local access on satellite TV.

The second issue that I intend to address this evening is the Brooklyn Art Museum in New York City. I have gotten a number of phone calls into my office from people who appear somewhat confused on my position in regard to that. I want to make sure this evening that position is clarified.

Then I intend to move on to the third subject, which will consume most of my time this evening as I address my colleagues, and that is the anti-ballistic missile treaty. My comments will be highlighted by the term, and Members have heard it before, the race against time.

What is the anti-ballistic missile treaty and what is the impact that the anti-ballistic missile treaty has on us all as average citizens? What is the threat to this country of continuing to try to comply with the terms of the anti-ballistic missile treaty?

I will go into a definition of what the anti-ballistic missile treaty is, about our national defense against missiles, and I think we will have at least some detail for a somewhat educated exchange this evening on the pros and the cons of the anti-ballistic missile treaty.

Mr. Speaker, let me begin with satellite reception across the country. As I mentioned, my district is the Third Congressional District in the State of Colorado. My district is unique in geographic terms in that this district has the highest elevation of any district in the United States. We have over 54 mountains above 14,000 feet. TV reception in the Third District of the State of Colorado is as important to the people of the Third Congressional District of Colorado as it is to the people in New York City, or as it is to the people in Kansas, or as it is to the people in Los Angeles, or up in Seattle.

TV has become a very important part of our lives. Now, I am not this evening trying to get into the pros and cons of watching television, but I am getting into the ability to have local access through satellite. Many of my constituents, and many of my colleagues' constituents, if they live in rural areas especially in this country, or even if they live in an urban area but have some challenges because of geography or buildings or things like that, are looking to satellite for their TV reception. And I think it is important that these satellite receivers, the users, have an opportunity to have local access, which they have been denied for a period of time.

We have a bill right now that passed out of the House overwhelmingly, passed out of the Senate overwhelmingly, and we have the two bills now in what is known as a conference committee. My good friend, the Senator from the State of Utah, is the chairman of that conference committee, and I am assured that that conference committee is working very hard to come out with some type of compromise so that those constituents of ours who are using satellites will have an opportunity in the not-too-distant future to have the right to local access.

I am confident that we can conclude this in such a manner that it will not be damaging to the other competitors out there but will allow satellite to be at least at the same level as cable TV.

Now, Mr. Speaker, let me move to the second subject, the subject that some of my colleagues who have been on the floor when I have spoken before know I feel very strongly about.

I will precede my comments by telling my colleagues that at times in the past I have supported government involvement in certain art projects. I think art is fundamentally important in our country. I think there are a lot of things about art that help our society become more civilized and so on. But that said, I, like all Americans, have limitations. And those limitations, of course, were tested, intentionally tested, recently by the Brooklyn Art Museum in New York City.

Let me explain what is happening at that museum. That museum, which is funded in part, in large part, by taxpayer dollars, by taxpayer dollars, decided to put on a show, an art show, an exhibit, that displayed, amongst other things, the Virgin Mary, which is a very significant symbol of the christian religion, but to exhibit a portrait of the Virgin Mary with, for lack of a better word, although they say dung in my country they understand it as crap, with crap thrown on the portrait. It is disgusting. The artist knows it is disgusting, the Brooklyn Art Museum knows it is disgusting, and the directors of the Brooklyn Art Museum know it is disgusting.

But they have decided to defy what I think is common sense, and they have decided to stand up and say it is their right, trying to paint it under the constitutional right of freedom of speech, it is their right to use taxpayer dollars, taxpayer dollars, it is their right to use those dollars to pay for this exhibit. I disagree with that.

Now, let me say at the very outset, so that I am perfectly clear, this is not, this is not an argument about the first amendment of the Constitution, freedom of speech. No one that I have heard, no one that I know has said that this exhibit, as sick as it is, should be prohibited from being shown somewhere in the country by any individual. We believe very strongly in this country about the freedom of speech and about that first amendment in our constitution. That is not the issue here. They have tried to paint the issue as a first amendment issue. It is not a first amendment issue.

The issue here is very clear. Number one, should taxpayer dollars be used to pay for this exhibit? Now, some people say, well, how do we decide what is offensive? How do we decide when taxpayer dollars should be used or should not be used? The decision, to me, is pretty easy, and I am sure the decision to a number of my colleagues is pretty easy. It is called a gut feeling. I wonder how many of my colleagues out there would take a look at the portrait of the Virgin Mary with dung, or crap, thrown all over it and their gut would not tell them that something is wrong; that this is not right; that this should not be happening.

Now, to me, that decision would be no more difficult than looking at a portrait of Martin Luther King with crap thrown all over it. That is not right. It should not be exhibited with taxpayer dollars. And whoever would do that is sick, in my opinion. It is not a display of art. But there is that right of freedom of speech.

I can tell my colleagues what has happened in the Brooklyn Art Museum is they have decided to put that exhibit up and they have decided to test it and