high expectation. We will compare that with a Japan, where 50 percent of 3-year-olds and 92 percent of 4-year-olds are in school, most of it paid by public sources, some by private sources. In Germany, 53 percent of 3-year-olds and 78 percent of 4-year-olds are in school, almost all of which is publicly financed. In the United Kingdom, 47 percent of 3-year-olds and 92 percent of 4-year-olds are in school, almost all of which is publicly financed.

Then as we watch as they progress, oftentimes, and I guess it is still true in Japan, what they are going to do in life was pretty well determined by the kindergarten they got in. This was true throughout the industrial world. Oftentimes when someone got to middle school, that decision was not made by the person, what they were going to do, it was made by what the test results were.

So we have to be careful when we compare apples with oranges when we say how poorly we do. Yes, 50 percent of our children unfortunately are in failing situations. Yes, it is a Federal issue. It is a national issue.

Our forefathers would be dumbfounded that there would be those in the Congress who would try to hide behind what they have written as our founding documents to say that there is no responsibility on the Federal level in relationship to functional literacy and illiteracy in this country, that it is strictly a State and local responsibility.

When I tried to improve Title I, I got the same story from our side of the aisle, Oh, we cannot demand excellence from those programs. Well, it is the taxpayer who is paying for the program. Should we not demand excellence for the money we are spending, the taxpayers' dollars?

☐ 2015

Let me close by reading an editorial I recently saw in the Easton Express Times, which is a newspaper that is not in my district, but in the State of Pennsylvania, and I will just read a portion of it. ''The Even Start learn-to-read program deserves increased Federal funding. Few things can narrow people's lives more than being unable to read. While other ways exist to get news and information about the world, illiteracy keeps its victims from reading danger warnings, understanding provisions of a contract, or discovering the joy that a good book, magazine or newspaper can provide. It can also limit a workers advancement or prevent employers from hiring workers,'' as I just pointed out how we are going outside this country to get all of those workers, ''certainly a present-day problem with low unemployment.

''Thus, it is entirely appropriate for the Federal Government to continue to take the lead in sponsoring programs that will empower people by teaching them to read. One such program, Even Start, which has been in place for 6 years locally in Easton is under the funding microscope.

''Even Start teaches parents how to read so they can work with preschool children on reading, and also provides preschool care and education.''

The project director says ''the program's goal is to break the cycle of illiteracy and poverty by improving educational opportunities for poor families. Further, programs like Even Start serve as a sound investment to prevent the continuing cycle of poverty.''

And then the editor says ''who among us would argue against breaking the changes that link many people to a life of destitution? Who indeed.''

I repeat, how can we say it is anything other than a national problem when it is probably the one major problem facing us that could bring this great Nation down from within.

Mr. Speaker, I would encourage all on my side of the aisle to understand that what we may think of as that ideal family and the help that they get from their parents may not be true for 50 percent of the youngsters in this country; they need our help. We need them for a great future.

MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). 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 am going to speak tonight on managed care reform, HMO reform. About a week or so ago, the Senate had a short debate and voted on the Nickles amendment, which was the GOP Senate version of patient protection.

Now, that amendment was given to Members with very short notice during that debate. I have the full text here. As one can see, it is quite dense. It consists of 80-some pages of legislative language, and so it was not easy to read through this so-called patient protection bill to understand exactly what was in the bill.

Mr. Speaker, I advised several of my Republican Senate colleagues to be very careful about voting for that bill, unless they had had a chance to review the specific language, because, as Members of both sides of the aisle know, the devil is always in the details in terms of whether a bill is a good bill or bad bill.

Over the last several days, I have had the opportunity to start reading the Nickles bill from the Senate, and it sadly is deficient in several areas. I would liken this more as an HMO protection bill rather than a patient protection bill.

Mr. Speaker, I am going to go into some detail about why that is, but it is very important for colleagues on both this side of the Capitol, as well as the other side of the Capitol to understand what is in this bill, because we passed a strong patient protection bill here on the floor of the House of Representatives in October of last year, the Norwood-Dingell-Ganske Bipartisan Consensus Managed Care Reform bill, and it had significant bipartisan support, not just 1 or 2 Members of one party, but 68 Republicans supported that bill, despite intense opposition by the HMO industry. So we have something to compare the Senate bill to.

As my colleagues on both sides of the aisle know, there has been a conference going on between the bill that passed the House and the bill that passed the Senate. I would say that the conference is not over, neither the Republicans nor the Democrats in the conference have said that the conference is over, but nothing much is happening now.

I think it is useful to go into some of the details of the Senate bill. The Senate bill limits many of its patient protections to only those Americans in self-insured plans. In fact, more than 135 million Americans would not receive most of the patient protections identified in the GOP Senate bill, including access to routine OB/GYN care for women, and pediatric care for children, continuity of care for terminally-ill patients, patients receiving in-patient and institutional care, and pregnant patients in their second trimester of pregnancy.

It would not include specialty care or access to specialty care, health care professionals for 135 million Americans; 135 million Americans would not have access to a point-of-service option. We have dealt with gag clauses that HMOs have put out in Medicare legislation that passed both the House and the Senate several years ago that prohibits contractual clauses that HMOs would try to limit the amount of information that a doctor could tell a patient without getting an expressed okay from the HMO; that would not be covered for more than 135 million Americans in the Senate bill.

The GOP Senate bill for 135 million Americans would not cover emergency medical screening exams or stabilization treatment. There are many different things.

I want to talk for the longest part of this special order about the Senate GOP plan's biggest fault, and that has to do with the enforcement provision or the liability provision.

Mr. Speaker, I have here an analysis of the Nickles GOP Senate bill by Professor Sara Rosenbaum, who is a Harold and Jane Hirsch Professor, Health Law and Policy at George Washington University; Professor David Frankford, Professor of Law at Rutgers University; and Professor Rand Rosenblatt, Professor of Law at Rutgers University School of Law.

I am going to primarily read this analysis. I think it is very important to get this into the CONGRESSIONAL RECORD. This is their analysis. I know Professor Rosenbaum personally. I respect her opinion and legal expertise a lot. This is how it goes.

By classifying medical treatment injuries as claims denials and coverage decisions governed by the Employee Retirement Income Security Act, the

Senate bill, this is the Senate GOP bill, insulates managed care companies from medical liability under State law.

Section 231 of the Senate bill, and I have that here, amends ERISA section 502 to create a new Federal cause of action relating to a denial of claim for benefits, quote unquote, in the context of prior authorization.

Now, this is all kind of technical language, but I will try to make this clear as we go through. The bill defines the term, quote, claim for benefits as a request for benefits, including requests for benefits that are subject to authorization of coverage or utilization review, or for payment, in whole or in part, for an item or a service under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan, end quote.

Thus, the bill would classify prior authorization denials as claims for benefits that are in turn covered by the new Federal remedy. You have to remember that Federal remedies under ERISA section 502 preempt all State law remedies.

This classification in the Senate GOP bill would have profound effects, particularly in light of the recent Supreme Court decision Peagram versus Herdrich. As drafted, the Senate bill would preempt State medical liability law as applied to medical injuries caused by the wrongful or negligent withholding of necessary treatment by managed care companies.

The Senate GOP bill thus would reverse the trend in State law which has been to hold managed care companies accountable for the medical injuries they cause, just as would be the case for any other health provider.

In recent years, courts have considered the issue of managed care relating injuries, have applied medical liability theory and law to managed care companies in a manner similar to the approach taken in the case of hospitals. Thus, like hospitals, managed care companies can be both directly and vicariously liable for medical injuries attributable to their conduct.

In a managed care context, the most common type of situation in which medical liability arises tends to involve injuries caused by the wrongful or negligent withholding of necessary medical treatment; otherwise known as denials of requests for care.

Now, State legislatures have also begun to enact legislation to expressly permit medical liability actions against managed care companies. The best known of these laws is a medical liability legislation enacted in 1997 by the State of Texas and recently upheld in relevant part against an ERISA challenge by the United States Court of Appeals for the 5th Circuit.

My friends and colleagues from both side of the aisle, you should know that the Senate GOP bill would preclude Texas law. In the case Peagram versus Herdrich, the Supreme Court implicitly addressed this question of whether managed care State liability law should cover companies for the medical injuries they cause.

The court decided that liability issues do not belong in Federal courts and strongly indicated its view that in its current form ERISA does not preclude State law actions. It is that decision that the Senate bill would appear to overturn.

□ 2030

Mr. Speaker, continuing this legal analysis of the GOP Senate bill, in the Supreme Court case Pegram, the Supreme Court set up a new classification system for the types of decisions made by managed care organizations contracting with Employee Retirement Income Security Act plans, ERISA plans. The first type of decision, according to the court, was a peer eligibility decision. In the ERISA context, that constitutes an act of plan administration and thus represents an exercise of ERISA fiduciary responsibilities. Remedies for injuries caused by that type of determination would be addressed under the ERISA law which currently provides for no remedy other than for the plan to provide the benefit itself.

But then the Supreme Court dealt with a different type of situation. The second type of decision is, according to the Supreme Court, a mixed eligibility decision. While the court's classification system contains a number of ambiguities, it appears that, in the court's view, the second class of decision effectively occurs any time that a managed care company, acting through its physicians, exercises what is called medical judgment, regarding the appropriateness of treatment.

Such decisions as medical decisions rather than pure eligibility decisions are not part of the administration of an ERISA plan and thus not part of ERISA's remedial scheme because, according to the Supreme Court, in enacting ERISA, Congress did not intend to displace State medical liability laws.

The court thus strongly indicated that these claims are not preempted by ERISA and may be brought in State court. In the court's view, these mixed decisions represent ''a great many, if not most'' of the coverage decisions that HMOs make.

So what we have is a situation where the GOP Senate bill is actually, through legislative language, trying to change the Supreme Court's recent decision, which held that, where one has decisions related to medical judgment and not pure eligibility, for instance, a plan that says we are not going to cover liver transplants, that is pretty straightforward, if a patient needs a liver transplant, but the plan explicitly in the contract says we do not provide liver transplants, that is a coverage decision.

But let us say one has a patient like some of the patients I have taken care of prior to coming to Congress, I was a reconstructive surgeon, let us say one has a child born with a cleft lip and a cleft palate, and the plan then says, oh, that is a cosmetic procedure, that is a medical judgment, the Supreme Court in Pegram versus Herdrich is saying that, if that HMO's decision results in a neglect injury, they should be liable according to State law.

But the Senate GOP bill is trying to change that Supreme Court decision. The Senate bill would appear to reverse Pegram by effectively classifying all prior authorization determinations as Section 502 decisions without any regard as to whether they are, ''pure'' or ''mixed''.

As a result, State medical liability laws that arguably now reach mixed decisions apparently would be preempted by the Senate GOP bill, leaving individual physicians, hospitals, and other health providers as the sole defendants in a State court when the HMO has actually made the decision.

Under the complete preemption theory of Section 502, remedies against managed care companies would now be governed by the new Federal remedy, which would effectively shield the industry from accountability under State law.

See, it is not easy to read through this legislative language when one is given a bill 15 minutes before it appears on the floor. It is not easy to make these kinds of arguments to understand what the language is showing when a bill is kept in secret and then brought up as an amendment on the floor. So that is why we are going through this tonight in some detail.

The Federal ''remedy'' in the Senate bill would leave Americans basically with no remedy. If one looks closely at the Senate GOP bill, the new Federal remedy simply creates the illusion of relief while at the same time foreclosing other more meaningful approaches to holding managed care accountable.

Now, here are some specifics as outlined by Professors Rosenbaum and Frankford and Rosenblatt. This liability provision in the Senate GOP bill is unclear on the meaning of the term ''denial'' in the context of claims that are actionable under the new Federal remedy. Were the remedy to be interpreted by the courts to encompass only outright denials, many of the worst types of HMO treatment delays would go unaddressed.

Here is an example. A recent decision from New York, Aetna U.S. Health Care used a series of appalling tactics to delay making any decision regarding treatment for an individual with profound mental illness related problems over 7 months. When the New York State Department of Insurance finally ordered coverage, it was too late. The patient died 8 days before Aetna finally entered a favorable initial determination.

So my colleagues see, the Senate GOP bill says that a negligent action can only be brought to trial if there is actually a denial. But what happens

frequently is that HMOs will string patients out, they will delay and delay and delay and delay. In this case, for instance, in New York, if the patient dies before making that denial, then, under the Senate GOP bill, HMO is not liable. That is a huge loophole.

By focusing only on denial itself and not covering delays, the Senate GOP bill effectively would incentivize the HMO industry to put patients through a delay after delay after delay as a strategy for avoiding any liability.

The Senate GOP bill also bars any actions that challenge the company's denial of treatment that it asserts to be ''excluded'', rather than not medically necessary.

I have come to the floor many times to talk about how HMOs will deny treatment on the basis of it not being medically necessary. That is the terminology that they will use. Then they will use their own definition of medical necessity and can do that under Federal law.

But the Senate Republican bill basically creates a loophole that would encourage companies to classify denials as exclusions rather than as denials of claims based on a lack of medical necessity.

The irony is that the external review provisions of the Senate bill seem to permit review of decisions involving analysis of medical facts, a broader standard of review than a strict medical necessity standard. But despite this, the remedy would bar any relief for an individual whose denial is couched in exclusion terms, rather than medical necessity terms.

Now, I will just have to tell my colleagues that any good HMO insurance lawyer is going to advise his HMO to draft all denial letters in a manner that conforms to that limitation on remedies, another big loophole for the HMOs in the Senate GOP bill.

Here is another one. In the Senate liability provision, in order to successfully prove a claim, the injured party would have to prove, not only a negligent denial, a denial that was made by incompetent staff or using incompetent standards or using insufficient evidence, but would have to prove that the denial was made in bad faith.

So let us say that this HMO makes this denial and one's son or one's daughter is injured because of that. Not only does one have to prove under the Senate GOP bill that it was a negligent decision, one also has to prove the motives. One is going to have to prove that it was bad faith. That is a virtually impossible standard to prove, and it is particularly egregious in light of the fact that plaintiffs cannot even bring such an action under the Senate bill unless they have gotten a reversal of the denial at the external review stage.

Even where they have proven that a company wrongfully withheld treatment, the injured party can recover nothing for their injures without taking the level of proof far beyond what is needed to win at the external review stage. Under the Senate GOP bill, virtually all injuries would go uncompensated.

Here is another problem with the enforcement provision in the Senate GOP bill. The injured party would be forced to show ''substantial harm'' defined in the law as loss of life, significant loss of limb or bodily function, significant disfigurement, or severe chronic pain. But that definition excludes some of the most insidious injuries, such as a degeneration in health or functional status or loss of the possibility of improvement that a patient could face as a result of delayed care, particularly a child with special health needs.

I almost wonder whether this provision was put into the Senate GOP bill specifically to address the case Bedrick versus Travelers Insurance Company. The managed care company cut off almost all physical and speech therapy for a toddler with cerebral palsy.

The Court of Appeals in one of the most searing decisions ever entered in a managed care reversal case found that the company had acted on the basis of no evidence. With what could only be described as outright prejudice against children with disabilities, the managed care companies medical director concluded that care for the baby never could be medically necessary because children with cerebral palsy have no chance of being normal.

The consequences of facing years without therapy were potentially profound for that child. Failure to develop mobility, the loss of a small amount of motion that a child might have had, a small amount of motion that could make a big difference in terms of a child's function, and the enormous cost both actual and emotional suffered by the parents. Arguably, none of those injuries fall into any of the categories in the Senate GOP so-called patient protection bill.

Here is another problem. The maximum award in the Senate GOP bill permitted is $350,000, and even that amount is subject to various types of reductions and offsets. That limitation on recovery can make securing adequate representation pretty difficult.

To compound that, in order to mount a case involving bad faith denial of treatment that we have talked about, that is an enormously expensive proposition. The limitations on recovery are in addition to the fact that the Senate bill gives Federal courts exclusive jurisdiction over cases brought under the new provision.

The costs and difficulties associated with litigating a personal injury claim requiring proof of bad faith would thus be exponentially increased, and it would make it virtually impossible for injured people to find attorneys to represent them. The deck is stacked in that Senate GOP bill against an injured patient.

□ 2045

I see my colleague from New Jersey. Would he like to enter into this?

Mr. ANDREWS. If the gentleman would yield, let me first begin by commending him for his tireless advocacy night after night, week after week, year after year on behalf of health care and patients in our country.

My friend from Iowa is a physician first and a Member of Congress second, and I say that as a compliment. He has carried his Hippocratic oath to the halls of this chamber and he has done so, Mr. Speaker, with great distinction, and I want to commend him as a Member of the opposite party, as a Democrat, commending my friend from Iowa, as a Republican, for his work on this issue.

I was listening to him tonight, Mr. Speaker, and I wanted to just supplement what he so very ably is saying in two ways, because I too have read the legal analysis that my friend from Iowa makes reference to. I am proud that it was produced by, in part by two scholars from my district, from the Rutgers University School of Law in Camden, New Jersey, Dean Rand Rosenblatt and Professor David Frankford were among two of the three authors who did such an outstanding job on that, and Sara also was fabulous and I do not want to omit her, from George Washington University.

Let me say, first of all, the remedy that is in the bill in the other body is a remedy in form only. It would not have the compensatory or deterrent effect that a real remedy has. And I believe, frankly, it is designed to be deficient in those ways. It would make people less than whole. A person who is denied the ability to see an oncologist and contracts a form of debilitating cancer would not be made whole by the bill in the other body. A person who is advised that he or she needs a test and does not get that test and suffers a fatal or debilitating injury will not be made whole by the bill in the other body. The damage limitations are arbitrary and capricious.

The second problem is the lack of a deterrent effect. The value of the real accountability that is in the bill that passed this House authored by our colleagues, the gentleman from Georgia (Mr. NORWOOD), by the gentleman from Michigan (Mr. DINGELL), and by the gentleman from Iowa (Mr. GANSKE), the value of that bill is not the lawsuits that would be brought under it, it is the lawsuits that would never have to be brought as a result of it because a managed care company making an arbitrary and unreasonable decision contrary to the best medical interest of the patient would be held strongly accountable. And when that managed care company weighs the balance that it has in front of it, it would more than likely choose the side of granting the care. It would choose the side of following the duly-given advice of the professionals who gave the advice in the first place. It would restore the primacy of the doctor-patient relationship to American medicine. And that is what this is about.

The third point that I would make is that we very often hear from the opponents of the Patient's Bill of Rights and from the supporters of the Senate ersatz version that our bill would lead to a flood of litigation; that it would put lawyers in the place that doctors ought to be. And there is a certain superficial appeal to that argument. I understand, Mr. Speaker, that Americans do not want the right to sue, they want the right to the treatment they have paid for and deserve. But without the right to sue, without the right to hold people accountable in a meaningful way, that care and treatment is going to continue to be arbitrarily and unreasonably withheld by the oligarchs of the managed care industry.

And people are not going to sit and wait for us to do something about it. Instead, they are already marching to the courthouse door in State and Federal Courthouses around this country. As a result, we are now witnessing what I would call a crazy patchwork quilt of legal decisions all designed to get around this unreasonable barrier that exists in the present law that says that under the normal law of tort, under the normal law of responsibility, managed care companies are immune from that responsibility. So we have theories about unauthorized practice of medicine, and we have theories about civil racketeering, and we have theories about unlawful conspiracy, and we have theories about denial of quality of care.

To those who fear a flood of litigation if the Norwood-Dingell-Ganske bill becomes law, I would say that that fear is misplaced; that if the Norwood-Dingell-Ganske bill does not become law, we can be assured that there will be a flood of litigation by dissatisfied Americans. And instead of that litigation being predictable, under a clearly established set of legal rules and principles written in the statute by us as the duly-elected representatives of the people, instead those rules will be written on an ad hoc, case-by-case basis by State and Federal judges around this country. So I would suggest that that is the flood of litigation that people should most fear.

So I want to thank my friend for yielding his time. I again salute him for his truly heroic and tireless work on this issue, and I assure him that the day is coming when his efforts will bear fruit and this bill will be signed into law.

Mr. GANSKE. Reclaiming my time, but I hope the gentleman will stay for a few minutes, because some of the things in that Senate GOP bill relating to the liability provisions are just amazing. Let me just relate a couple more for the gentleman.

There is a provision in that Senate GOP bill that says that any group health plan that offers its members the choice of either an insured benefit or an individual benefit payment to be used by the Member to buy an individual insurance policy could not be held liable.

What does that mean? That means that any employer could say to an employee that they have a group health plan that they can join, or they can be offered a payment to buy their our own health insurance. In that situation, the HMO and the employer could not be held liable, specifically by the language in the Senate GOP bill. There would be no liability.

Now, the problem with that is that, as most people know, as an individual it is very difficult to go out and purchase our own insurance. So that what we would have is, we would have every employer in the country that offers health insurance saying, well, here is an option for you. You can buy your own insurance. Of course, no one will do that because they will not find any individual insurance for their family. But in so doing, then they totally exclude those plans from any liability for a negligent decision that they would make.

Mr. ANDREWS. If the gentleman will yield, I want to explain the consequences for what he has just correctly stated for constituents in my State.

In my State of New Jersey, an individual buying family health insurance would pay in the neighborhood of $10,000 a year. But the price that would be offered through the group plan would be considerably less, probably $6,500 to $7,000 a year picked up by the employer. So let us say the employer gives the employee a $6,500 voucher toward the purchase of health insurance. The choice that my constituents would face under this Senate bill that my friend talks about would be to either have the right to hold the HMO accountable and pay $3,500 for that privilege, which the constituent clearly would not have, or not have the right to hold them accountable.

Now, that is like saying to someone that we are going to give everyone in America the right to buy a Mercedes Benz for $75,000. Nice right to have in theory, but if a person does not have the money to afford it, they cannot do it.

Mr. GANSKE. Here are a couple other provisions in the Senate GOP bill. Remember, this bill made its first appearance in the light of day about an hour before it was offered on the floor, and it was offered to the minority about 15 minutes before it was offered. So not much chance to review the language. And that bill has never had any hearings.

There are a couple of provisions in there that are very significant. One provision would basically preclude class actions under the new ERISA remedy in the Senate GOP bill no matter how widespread the misconduct of the defendant. For example, an HMO might engage in a practice of systematically denying every request for treatment in order to push individuals into external review and delay treatment.

They could just do that all the time. They could deny, deny, and push everybody into an external appeals thing. They could save a lot of money on the float that way. But under this provision that is in the Senate bill, even were the defendant pursuing such a strategy as a matter of design, the way they are setting up their plan, an individual could not seek any class action relief.

Here is another problem. We know from a case, Humana v. Forsythe, that the United States Supreme Court held RICO applicable to a managed care company that has systematically defrauded thousands of health plan members out of millions of dollars in benefits by systematically lying to members about the proportional cost of the treatment they were being required to bear.

This is how it worked. This HMO had gotten discounts from hospitals, but the hospitals would send the full price bill to the patient. The patient typically had an 80/20 policy, meaning that the health plan is supposed to cover 80 percent of the cost and the patient is supposed to cover 20 percent. So they would get the full price bill from the hospital and then Humana would tell them that they had to pay 20 percent of that full price bill, even though Humana was only paying a fraction of the 80 percent because of a discount. In other words, they were leaving their beneficiaries paying a much higher percentage of the bill so that they could pay even less than their discounted part.

Well, that was looked at, and the Supreme Court held that Humana was fraudulently lying to its beneficiaries and ordered a multimillion dollar settlement. That is a proper use of the RICO statute. Under the Senate GOP bill, that would be precluded. A patient could not do that.

Mr. ANDREWS. If the gentleman will yield briefly, under the facts as the gentleman just outlined them, let us say the patient had a $1,000 hospital bill, as legitimately presented, and the HMO only paid $800. Under the terms of the contract, the patient would be liable for one quarter of that $800: $200. But the way the bill was being presented to the patient, the patient would pay $250. Now, $50 is a lot of money to people, but it is not enough money to retain an attorney and file suit and pursue the claim.

Those kind of claims only get meaningfully pursued through class actions. If thousands of people are owed $50, the economic incentive exists for someone to file suit and pursue the claim. But if a patient cannot do that through a class action, person after person after person who is defrauded out of their $50 will never pursue a legal remedy. And that is another deficiency in the Senate bill.

Mr. GANSKE. Let me just finish in reading the conclusion from Professors Rosenbaum, Frankford, and Rosenblatt.

''The central purpose underlying the enactment of Federal patient protection legislation is to expand protections for the vast majority of insured Americans whose health benefits are derived from private nongovernmental employment and who, thus, come within the orbit of ERISA. Not only would the GOP Senate measure not accomplish this goal, but, worse, it appears to be little more than a vehicle for protecting managed care companies from various forms of legal liability under current law. Viewed in this light, congressional passage of the Senate GOP bill would be far worse than were Congress to enact no measure at all.''

Now that is a sad commentary on a bill. But as I have been looking through the Nickles bill, I can come to almost every page and have questions about the legislative language.

I will just talk about this one.

□ 2100

One of the things that we should be able to reach a bipartisan consensus on is how do you do an external review and should the external reviewer be independent?

Let us say that an HMO denies care to your child. Your doctor says the kid needs the care. So you go through an appeals process within the HMO. The HMO still says, ''No, we're not going to give that care. It doesn't meet our own definition of medical necessity.'' So you say, I want an independent review. And let us just say the Senate GOP bill had become law. Would that reviewer be independent under the Nickles independent review plan? Looking at the language, it is real interesting. The language says that the reviewer could consider the claim under review without deference to determinations made by the plan. Could consider but not be bound by the definition used by the plan of medically necessary.

Then the next clause is very important. Notwithstanding the independent reviewer would have to adhere to the definition used by the plan or issuer of medically necessary or experimental investigation if such definition is the same as, one, that which has been adopted pursuant to State statute or regulation or, two, that which is used for purposes under titles 18 or 19 of the Social Security Act.

So what does that mean? I looked at this for a while and I wondered, because in the bill that passed the House, we just say that that independent reviewer will be able to determine medical necessity looking at a number of factors and as long as that benefit was not explicitly excluded in the contract, then the reviewer would be able to determine medical necessity. But here they have added a couple of provisos. They say the medical reviewer has to go use the definition of the plan, what the plan says is medically necessary if that has been adopted pursuant to a State statute.

Well, I know exactly why that clause was put in there, because a year or so ago my home State of Iowa was doing some patient protection legislation, and I have some expertise in this so some of the State legislators came to me and asked me about some specific language that had been provided by the insurance industry. In that language very cleverly they had a provision that basically said medical necessity is what we define it to be, i.e., what the plan defines it to be. So if that happens to be what is in State law, then this independent reviewer cannot do anything except decide whether the plan has followed its own definition.

Mr. ANDREWS. There is another grave danger here. And, that is, that the HMOs will certainly take the position that even if there is not an explicit statutory definition of medical necessity in State law, that the State laws which permit them to incorporate their insurance companies carry with them the implicit right of the HMOs to fix by contract the definition of the terms of their contract. To sort of unpack that and put it in less legalese, they will take the position that State laws implicitly give them the right when they organize themselves to declare what definitions in their contracts mean, that it is a matter of contract. And I assure you that every HMO worth its salt will then put a boiler plate clause in their contract that says medical necessity means whatever we say that it means. So if your child's pediatrician thinks that it is medically necessary for your child to have an MRI but the reviewer for the HMO does not think so because the statistics show that very few 7-year-olds have a tumor problem, the HMO wins. That is a loophole that is very subtle but very disingenuous and very dangerous.

Mr. GANSKE. Reclaiming my time, here is another loophole in the Senate GOP bill. Who gets to select that external reviewer according to the Republican plan in the Senate? On page 47, the plan gets to select that, quote, independent reviewer. That certainly was not in the version that passed the House.

Here is another loophole. Does that independent reviewer, is that in the House bill a person who has expertise related to that problem? You betcha. What about in the Senate? Only if a specialist is, quote, reasonably available would you get, for instance, an orthopedist reviewing an orthopedic problem. These are just multiple things that you can go through nearly every page.

Mr. ANDREWS. The gentleman has just very eloquently described what in sports we call the home field advantage. Imagine if the home football team got to pick the referees for every game at its stadium without any consultation with the visitors or with the conference in which they play. The home team would win a lot of the games. If you were an external reviewer, external reviewer A has a track record of favoring the HMO three-quarters of the time and external reviewer B has a track record of favoring the HMOs one-quarter of the time, and the reviewers get paid according to the number of reviews that they do and the HMO gets to pick the reviewer, you can imagine which reviewer is going to get more work and what message is going to be sent out to the reviewers. That is a home field advantage if I have ever heard of one and it renders the Senate external review procedures to be farcical in my opinion.

Mr. GANSKE. Let me give the gentleman another example from the Senate GOP bill. The bill contains a prohibition on plans from requesting or requiring predictive genetic information. An exception, however, allows plans to request but not require such information for diagnosis, treatment or payment.

The problem is that the plan can request that information but does not have to tell the patient that they do not have to give them the information. See, that is the type of little legislative language tricks that you can put into a bill.

Here is another one. The Senate GOP bill allows plans to fulfill their disclosure obligations by providing prospective enrollees with, quote, summaries, or, quote, descriptions or, quote, statements of beneficiary rights rather than specifically enumerating those rights such as in the bill that passed the House.

These are, I think, minor provisions. They are not as important as the one related to enforceability, the one related to whether that independent reviewer is actually independent, whether that independent reviewer, where there is a difference of opinion on whether care should be provided or not, is competent or knowledgeable in that area. But there is still, in aggregate, important provisions for those individuals.

As you pointed out earlier, I believe firmly that the bill that passed the House, the Norwood-Dingell-Ganske bill because it is written to actually protect patients and provide them with due process will in the long run decrease legal activity rather than increase it. It will prevent the injury from happening which would then require a legal remedy because it sets up a bona fide real process for dispute resolution. Unfortunately, we are just not seeing that in the language as we have gone through the Senate GOP bill.

I am going to provide my colleagues in the next few days with a more detailed analysis of the Senate GOP bill. I think it needs to be examined in-depth. I am very hopeful that as this process continues over the next several months, we will have an opportunity to correct the deficiencies.

Mr. ANDREWS. If the gentleman will yield one more time, I want to conclude my remarks by saying that the gentleman is not a member of the conference committee that is negotiating the final version of this bill. I am privileged to be a member of that. I suspect

that the gentleman is not a member of the conference committee because he holds, as do dozens of his Republican colleagues, the views that he has expressed tonight. This bill passed the House with 61 percent of the Members of the House voting for it, a broad bipartisan coalition. This is not a Republican or Democratic issue. I am hopeful as a conferee that we will return to the conference table, we will do so under the scrutiny of the public and the media, that we will discuss the issues that the gentleman has raised tonight, and that we will resolve our differences and give the President a bill that he can sign.

I have been on this conference since it initiated in March, and I said a few weeks ago that someone on the other side said the conference was sailing right along, and it was sailing right along smoothly and I said that they had used the wrong nautical analogy, that the conference was not sailing right along, that it reminded me more of the legislative equivalent of the Bermuda triangle, that good ideas go into the conference and are never heard from again. The gentleman has many good ideas. I commend him again for his good work and look forward to working with him to make this the law.

Mr. GANSKE. I thank the gentleman for joining me in this special order tonight. I look forward to working with him and other Members in a bipartisan fashion on both the House side and the Senate side to actually get signed into law a real patient protection piece of legislation.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4810, MARRIAGE TAX PENALTY RELIEF RECONCILIATION ACT OF 2000

Mr. DIAZ-BALART (during the Special Order of Mr. GANSKE), from the Committee on Rules, submitted a privileged report (Rept. No. 106–726) on the resolution (H. Res. 545) providing for consideration of the bill (H.R. 4810) to provide for reconciliation pursuant to section 103(a)(1) of the concurrent resolution on the budget for fiscal year 2001, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4811, FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 2001

Mr. DIAZ-BALART (during the Special Order of Mr. GANSKE) from the Committee on Rules, submitted a privileged report (Rept. No. 106–727) on the resolution (H. Res. 546) providing for consideration of the bill (H.R. 4811) making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2001, and for other purposes, which was referred to the House Calendar and ordered to be printed.

ILLEGAL NARCOTICS

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

Mr. MICA. Mr. Speaker, I am pleased to come before the House tonight as it concludes its business to address the House on a subject I normally do on Tuesday nights and one that I take a personal interest in as chairman in the House of Representatives of the Subcommittee on Criminal Justice, Drug Policy and Human Resources. And specifically always on Tuesday evenings, I try to address my colleagues and the American people on the topic of illegal narcotics and our national drug policy and our efforts in our subcommittee to attempt to develop a coherent policy to deal with probably the greatest social problem and challenge I think our Nation has ever faced in its history, a problem that has devastated and I think we have gotten to the point where almost every family in America is somehow touched by illegal narcotics. Certainly the impact in crime, the social costs, the costs that this Congress incurs in funding antinarcotics efforts, criminal justice, the system that is fueled by those who are committing crimes and offenses against society under the influence of illegal narcotics, the whole gamut of problems that have arisen as a result of illegal narcotics is really astounding.

I often cite when I speak before the House the most recent statistics of deaths. Direct deaths from illegal narcotics in the most recent year provided to our subcommittee, 1998, amounted to 15,973 Americans died as the direct result of illegal narcotics. The drug czar, our national director of the Office of National Drug Control Policy, Barry McCaffrey, again today used the figure in a hearing before our subcommittee of 52,000 Americans dying in a year as a result of direct and indirect illegal narcotics.

□ 2115

So the toll is mounting. The statistics continue to be alarming and should concern every American because, most of all, we find that this problem is affecting not those people who you would traditionally think have been victimized by illegal narcotics, the inner-city, the metropolitan, the high density areas, but every single corner of our Nation is now victimized by the effects of illegal drugs.

In fact, I cite a recent article, and it this headline says ''Drug use explodes in rural America.'' It shows that in fact in rural America that cocaine, that crack, that heroin and methamphetamines in all of the rural areas of the country are now experiencing an explosion.

One of the things that I try to do as chairman of the Subcommittee on Criminal Justice, Drug Policy and Human Resources is not only conduct hearings, such as we did today with the national Drug Czar on our national media campaign that we instituted several years ago, a $1 billion-plus program, $1 billion from Federal money over 5 years and an equally significant amount in contributions to the campaign required by the law that we established, but in addition to conducting the hearings and evaluations and oversight of our national drug policy and the programs that we have instituted, we attempt to conduct hearings throughout the United States.

Most of the hearings that have been conducted by our subcommittee are at the request of either my subcommittee members or Members of the House who are experiencing a similar problem. I can tell you without a doubt that in fact the entire Nation, from the Pacific coast to the East Coast, from the Mexican border to the Canadian border, is being devastated by illegal narcotics.

During the recent weeks we have conducted hearings and field hearings. One was in the heartland of America, in Sioux City, Iowa, at the confluence of three states, Nebraska, South Dakota and Iowa. This was a hearing at the request of the gentleman from Iowa (Mr. LATHAM). We heard absolutely startling testimony about the explosion of illegal narcotics, the explosion of methamphetamine, narcotics that have infiltrated that region of our Nation, and the devastation on the community, the cost in law enforcement, the cost in social services, the tremendous cost to that entire area that is being borne in destroyed lives.

So we have focused not only on hearings in Washington, but throughout the land, and we confirmed the headline which I cited here of the explosion of illegal narcotics and methamphetamine in particular in rural areas of our country.

It is also significant that we have presentations before our subcommittee that bring us up-to-date on what is happening, because we are a criminal justice, national drug policy oversight subcommittee. Some of the recent information we have had from the Center for Disease Control and other monitoring agencies indicate that over half the crime in this country is committed by individuals under the influence of illegal narcotics.

The National Institute of Justice drug testing program, found that more than 60 percent of the adult male arrestees across the Nation tested positive for drugs. In most cities, over half the young male arrestees are under the influence in fact of marijuana, and, importantly, the majority of the crimes that result from the effects of the drug do not result from the fact that the drugs are illegal.

According to a study by the National Center on Addiction and Substance Abuse, which is also referred to as CASA, at Columbia University, 80 percent of the men and women behind