We also go ahead, and we try to do a few other things and try to make sure that the people are aware of what their insurance policy covers and that they have an appeal process. If they think they should have some type of treatment, and they are not getting it, they can have an expert tell them what they are entitled to and what they are not entitled to. We think that is important. They ought to know that up front.

They also need to have their health records kept in confidence, that that information that their doctor accumulates or their pharmacy accumulates should not be handed off to another company so that they can be solicited for some type of medicine, that people's health care and their records of health care are sacrosanct, and that confidentiality ought to be in place.

No amount of money is sufficient. If we do not get the health care we need, if we do not get the type of service that we need, if we do not get the ability of continuing the access to health care that is there, those, I think, are the very, very important things.

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I had about 15 folks who worked with us on a very, very diligent basis and tried to put together a piece of legislation that worked.

At this time I would like to recognize my good friend from St. Louis, MO (Mr. TALENT), to whom I will yield the balance of my time.

REPUBLICAN MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. HANSEN). Under the Speaker's announced policy of January 7, 1997, the gentleman from Missouri (Mr. TALENT) is recognized for the balance of the hour as the designee of the majority leader.

Mr. TALENT. Mr. Speaker, I thank the gentleman from Illinois for yielding to me and for all his really excellent work on this bill. It is a great pleasure to get up and talk about the Patient Protection Act which passed the House this year. We made enormous progress in the direction of ensuring that people get the care that they need and that their physician has prescribed when they need it and that we could do that without big government. It was a great bill. It passed the House. Unfortunately it got caught up in politics and some partisanship both in the other body and on the other end of Pennsylvania Avenue and that is unfortunate. We have all heard some specimens of that this afternoon. But that should not keep us from talking about this bill and what it would do for people, because, as I said before, we have made an enormous amount of progress. We need to make progress in this area.

When I go around my district and talk with people about health care, they are concerned. It is less about the reach of the coverage that they are promised in their insurance. There is some concern about that. The concern is that if they get sick, they will not get the care they have been promised. They will not get the care that their physician has prescribed. They have some reason for that concern, Mr. Speaker. We have all heard about these horror stories around the country. They are not just horror stories, they are horrible stories. People losing their children because an HMO turned down the care that their physician had recommended, pregnant women not being allowed to go into the hospital when they have high-risk pregnancies, seniors being denied chemotherapy on the grounds that it was supposedly experimental. These are horrible stories. We should not have that. We do not have to have that. We can have a system that refocuses the health care system and the power in the system on the patient and on their physician. That is what the Patient Protection Act does. The gentleman from Illinois has talked about some of the good things in it. I am going to be yielding to people in a few minutes to go into greater depth on that.

Let me just say the bill does two things that are very important and it is the only bill that was before the House this year that did these two things: The first thing, it expanded the coverage that was available, good private sector coverage available to people around the United States. At any given time about 42 million people do not have health insurance coverage, working people. But they work for employers, typically small employers who typically cannot afford to provide the coverage to them. Our bill had a feature in it that no other bill had that we have needed to do for decades here that makes perfect common sense and would make good, solid, private sector health care available to millions of those people who currently do not have it. The gentleman from Illinois (Mr. FAWELL) is going to discuss it later, but briefly, Mr. Speaker, it is the concept of association health plans. All that means is that these small businesses who cannot afford them, they may only have 5, 6 or 10 employees and cannot afford to go through all the administrative costs and the hassle of offering health insurance, can pool together as associations. Then the association is a sponsor of a health plan and the small business can send its employees to that health plan, can put up some money for the employees, they put up some money on their own and they are able to buy health insurance from a plan that can offer them all the choices that currently employees of big companies have. Why should an employee just because he or she happens to work for a restaurant have no health insurance offered to him or her or have fewer choices offered to him or her than somebody would if they worked for IBM or they worked for Emerson Electric or they worked for Boeing or any other of the big employers in the country? This provision in the bill when we pass it out of here, and I think we will get it early next year because it is an idea whose time has come, will make health care available to millions who currently do not have it. It is the only bill that does that.

I will say, Mr. Speaker, we were enlightened on that issue when at a press conference a reporter asked a very important member of the other body what the administration bill does for the uninsured. He thought about it and said, with his typical candor, ''Not much.'' That is true. It did not do anything for the uninsured. This bill would make health care available to millions of people who currently do not have it. It is part of the whole idea behind this bill, to provide health care to people when they need it, when their physician prescribes it, without big government.

But the feature I am up here to talk about and I am going to be yielding to other Members of Congress to talk about other features in the bill, the feature I want to talk about, Mr. Speaker, is the accountability features in the bill. The gentleman from Illinois (Mr. HASTERT) referred to this generally, but what we did, we worked on this for months and months and came up with the tightest, best accountability procedure anywhere in this country to ensure that patients get the care their physician recommends at the time their physician recommends it, notwithstanding some bean-counter at the HMO. It is low-cost to the patient, it is easily accessible, it is quick, and it is certain. I think it is going to be a model that will be used in States, and I certainly hope in Federal legislation when we pass it next year.

Basically what it does is this: The problem now is that if you belong to a plan, an HMO, let us suppose your physician recommends care for you or your family. I will just take an example. Let us suppose, because I have three children, Mr. Speaker, 8, 6 and 2. None of them have a problem with their ears. Some kids have a constant problem with ear infections. With my kids it is sinus infections. With some people it is ear infections. Let us suppose that after two or three times the pediatrician says, for a 4 or 5-year-old, ''Look, we got to put in the ear tubes.'' That is a very common procedure. So you call up the HMO and they say, ''No, we don't think that's medically necessary. So we're not going to pay for the ear tubes.'' What would you do today? What would you do without this bill? You would either pay for the ear tubes yourself or you would file some amorphous appeal with the HMO that would take months and months and months and then they could turn it down and never tell you why and if you wanted to then you can go to court and sue them for the cost of putting in the ear tubes and who is going to do that? It is just not a feasible procedure for the average person who belongs to an HMO.

Under this bill what you could do is this: You could immediately file an appeal, what we call it is an internal review. The first stage is an internal review before a physician in the plan. It would have to be a physician. No more would the plan be able to turn down the care your physician has recommended on the authority of an accountant, or even a nurse or some other allied health care professional. So immediately you would get a review before a physician in the plan. That review would be either within 3 days if your physician said it was an emergency situation, 10 days if your physician said it was urgent care or 30 days if your physician said it was routine care. This would probably be considered, absent some kind of really bad side effect of the infection, a more or less routine situation. But that would be up to your physician, the treating physician, to say whether it was emergency, urgent or routine care. If the plan did not return a result from the appeal within the time limit specified in the statute, the appeal would be taken as granted and the care would be paid for, so they could not spin you out and deny the care just by indecision.

So you go before the plan physician. Let us say the plan physician backs up the plan, says, ''No, I don't think it's medically necessary, either.'' Then you would get an appeal to an external panel of independent specialists. Our bill was the only one that provided for easy, low-cost access to a panel of independent specialists in this field. In this case it would be pediatricians, and so the plan would have had to contract, let us say, with the Mayo Clinic or the local research hospital, they would make their pediatricians available, it would be a double-blind kind of situation. The plan would not know who the pediatricians were who were reviewing that case, the pediatricians would not know the name of the patient, just the information before them. Then these specialists would make a decision about whether it was medically necessary. If they said it was medically necessary and the plan still refused to pay for the care, you could go immediately to court. When you went to court, you could sue not only for attorney's fees, not only for the cost of the treatment, not only for the court costs but for a penalty of up to $1,000 a day up to $250,000 if they refused to pay the cost of providing those ear tubes. What are the plans going to do, Mr. Speaker? Under those situations they are going to say, ''We better pay because if we don't pay up front now, we're going to end up paying up front, we're going to end up paying in a few weeks anyway. And in addition we're going to have to pay all these attorney's fees and we're going to get whacked with this huge penalty.''

The key to this plan, and we have outlined it here, from the time the initial claim is denied, within a matter of weeks you get an internal appeal before a physician. It is the only bill that provides for that. You get an external review with no threshold. It does not have to be a $1,000 claim or a $5,000 claim or a $10,000 claim, and it should not be. If it is a $200 claim but it is required under the insurance contract, you should get it.

I yield to the gentleman from Georgia.

Mr. NORWOOD. There was another bill before us in Congress, those from the left had a managed care reform bill, too. Did they have a threshold in their bill?

Mr. TALENT. Yes, they did.

Mr. NORWOOD. Do you know what that threshold was?

Mr. TALENT. I will reclaim my time. I am sorry for stepping on the gentlemen's comment there, but they said it had to be a significant claim. Then it left that up to the Department of Labor to define. We said any claim that you feel you are not getting coverage on that you have been promised coverage, you can go to external review.

Mr. NORWOOD. Does that not mean, then, many cases of patients who were in HMOs who had a claim that was being denied, many of those people would not have an external appeals process through their plan, do I have that right?

Mr. TALENT. That is absolutely correct. I thank the gentleman for raising the point. We all know on that task force it was the gentleman through his efforts who made sure that this bill did not have a threshold. Then again, after external review if the plan still does not pay, you go to court immediately. You do not have to wait until your child has lost his hearing. You do not have to wait until somebody has got really sick and died and then maybe 4 or 5 years later after you have run the gauntlet in the State court system you can try to sue for recovery later on, you can sue right away for penalties up to $250,000 in addition to attorney's fees, court costs and the cost of the treatment. There are others who want to speak on this bill, Mr. Speaker. I am eager to have them do it.

Mr. NORWOOD. If the gentleman will yield further, I wanted to ask him a question, if I could, about the court remedy. One of the things I keep hearing is that under our bill, patients could not sue an HMO and under the Democratic bill they said you could sue an HMO. I believe that is incorrect information. Under our bill, you can sue HMOs, but, in fact, without our bill, you can sue HMOs.

Mr. TALENT. There is a major difference. Under our bill, you do not have to die first. You can sue to get the treatment that you need. Because the emphasis here, and I appreciate the gentleman's comments, I say, in all good faith, the emphasis here is on giving people the care they need when they need it. We want people in the treatment room, not in the courtroom. I would anticipate that very few people would have to go to court. Because we have changed the incentives in this bill for these HMOs. For the very same reason that they have been denying care in the past, they are going to be granting care now because they are going to know, it is going to end up costing them more money if they deny the care up front. So I would anticipate that few people would have to go to court. But that hammer is there. If they spin people along, if they do not pay when they are supposed to pay, you go to court right away. In fact, as the gentleman knows, you can go to court up front in an emergency situation to get an injunction, an emergency injunction to order them to pay. Florence COCHRAN, the very unfortunate lady who had a high-risk pregnancy and her doctor wanted her to go into the hospital and the HMO said, ''No, we don't think it's all that high risk a situation,'' she could have gone to court under our bill, got an injunction to allow her to go into the hospital right away and then because it was an emergency gone through this internal and external review procedure within about a week to establish the right that she had the right to have that hospital care paid for.

Mr. NORWOOD. If the gentleman will yield further, would Mrs. Cochran have been able to go into court immediately?

Mr. TALENT. Yes.

Mr. NORWOOD. Once the benefits of the plan were denied, she would have been able to get to court immediately. Because her case was not just routine care, it bordered at least on urgent and perhaps emergency. So she could have gotten into court immediately.

Mr. TALENT. And it would have been up to her physician to decide whether it was emergency or urgent care which then triggers the time limits in the bill. Moreover, if the plan had denied coverage after the external review panel had said it was covered, as the gentleman knows, the $250,000 penalty is a per diem penalty, a per day penalty. Every day they do not pay, they would be liable for up to $1,000. Why? Because we are not trying to promote litigation in this. We want the treatment covered when the physician has recommended it. And so what we are saying to the HMOs, ''Pay and don't delay because the longer you delay the more you're going to have to pay after a few weeks or months.''

Mr. NORWOOD. If the gentleman will yield further, I am not an attorney and I know that the gentleman is, but explain to us as an attorney how attorneys would be able to take cases today where benefits are denied and patients can sue their HMOs today for benefits, but what if the benefit was only $1,000? Can an attorney afford to take a case like that, that is $1,000, not knowing whether they will ever be paid for their services that may run up $20,000, their fees.

Now, the change in our bill, how does that help that?

Mr. TALENT. It would be borderline because under the law today you are

allowed attorney's fees. So it would be a borderline type of situation. In many cases the lawyer would just say and the patient would say, ''It's not worth it.'' Why do I want to go years and years and years in court with the plan having every incentive to spin out the case as long as possible? So ours is an improvement in a number of different respects. First of all, the $250,000 penalty, which is triggered by delay, we are saying to the plans, ''Every day you delay it costs you more. We want you to pay when this panel has said you should pay.'' In addition, you can go to court right up front to get an emergency injunction in those cases where a life is really at stake. Any judge is going to say, ''The treating physician has recommended this care, it's an emergency situation, there's some kind of a contract dispute, I'm going to put this person in the hospital while you take the necessary week or 10 days or whatever it is to resolve this matter.''

So we have expedited the process, it is low cost to the patient as the gentleman knows, it is swift, it is sure, it is certain, it is a way of getting people the care that they need. I will just say to the gentleman, then I will close and yield to the gentlewoman from New York to discuss a different aspect of the bill.

I was asked during this debate on the bill by somebody who said to me: Look, suppose they have this situation. A person has an infected leg, and his plan physician recommends institutional care in a hospital. The plan turns it down, the infection gets worse, the persons loses the leg, what can they recover? Under your bill, what could they recover from the plan?

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And I said, ''Well, they can get attorney fees, they can get costs, they can get $250,000 in penalty, they can get the cost of the treatment, and they get their leg because that leg is not lost.''

And that is the whole point. Nothing I think differentiates the different approaches that were before this House in that example.

We have written this as air tight as you can write it, and where that care is medically necessary, where the treating physician recommends it, the person is going to get the care that they need.

That is what America wants, and they want it without litigation, they want it without big government, they want people in treatment rooms, not in courtrooms, and, as in most cases, the American people got a lot of good common sense in this. That is what this bill would have given to them. I am very glad it passed the House. I think it is the starting point for legislation next year.

And I am very happy to yield to the gentlewoman from New York (Mrs. KELLY) for any comments she may wish to make.

Mrs. KELLY. Mr. Speaker, I rise today to join my colleagues from the House Working Group on Health Care Quality to reflect on the critical legislation passed by the House in July, the Patient Protection Act.

Mr. Speaker, unfortunately politics has taken precedence over policy with regard to reasonable health care reform. I want to share with Americans some key provision of the Patient Protection Act that will not come to fruition because some Members of this Congress would rather resort to demagoguery on the issue rather than actually do something to improve America's health care.

As my colleague has pointed out, we are interested in making sure all Americans have health care when they need it, not have to go to court to fight for it.

I have approached the health care debate from two different perspectives, the first from that of a professional patient advocate and the second from that of a former small business owner. As a professional patient advocate, I have dedicated my life to ensuring the sanctity of the doctor/patient relationship. It is that relationship, the relationship between a patient and their doctor that results in high quality care. To that end, the Patient Protection Act includes several provisions that recognize the distinctive health care needs of patients, especially women and children.

For example, the Patient Protection Act provides women with direct access to their OB/GYNs without authorization or referral by a primary care physician. It also gives parents a very important right, access to a pediatrician as their child's primary care provider.

Other patient protections in the bill include providing new avenues to health care coverage where quality and choice are available by requiring health plans to offer a point of service option. The measure also includes a prohibition on gag rules that are often placed on medical providers as well as ensures access to emergency care by eliminating preauthorization requirements for emergency services, allowing a patient to access emergency services from any emergency service provider and demanding that coverage is based on patient symptoms rather than a final diagnosis.

However, while it is of utmost importance for Congress to protect patients in today's managed health care market, it is also our responsibility to be mindful of producing a bill that does not have dire consequences such as making health insurance too expensive for American families and businesses.

The Patient Protection Act does not turn its back on the financial impact health care reform might have on families and businesses. The President's health care proposal does nothing to address the 42 million uninsured Americans, many of whom work for small businesses or are self-employed. In fact, the Congressional Budget Office reports that his proposal could result in a premium increase of 4 percent which would result in many Americans losing health care coverage. The Patient Protection Act, on the other hand, is the only health care reform proposal that creates new health care choices so that more, not less, Americans can have access to affordable health care.

Mr. Speaker, the Patient Protection Act recognizes that reform means nothing to those Americans who cannot access health care. The Patient Protection Act is an excellent starting point on the road to quality affordable health care for all Americans. It is my hope that next year Congress will rise above political rhetoric and demagoguery and protect America's patients and families as well as America's uninsured.

Mr. TALENT. Mr. Speaker, it is my pleasure now to yield to the gentleman from Florida (Mr. BILIRAKIS) for such comments as he would wish to make, and I will just add in yielding to him that Mr. BILIRAKIS has been a leader in this field both of health care reform and patient protection and access to health care for a number of years and did outstanding work in this task force, and it is a pleasure to yield to him.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding to me and for those kind remarks.

Mr. Speaker, Congress had a tremendous opportunity this year to expand health care access to the uninsured as well as to the insured and, at the same time, provide better protections for the patients of managed care providers.

Earlier this year the House completed its job and passed health care, health reform legislation. Unfortunately, the Senate was not able to debate and approve a similar bill. I am deeply disappointed by the fact that the Congress was unable to work in a bipartisan fashion and reach agreement in this very important issue, and I honestly feel let down because many days and hours, early and late, would have gone for naught because many needed patient protection reforms would not be available for patients.

This situation, Mr. Speaker, we are in today is similar to what we went through in 1994. At that time we had the Rowland-Bilirakis health bill sidetracked by the then Democratic majority leadership because the large number of cosponsors from both parties meant sure passage, sure passage if the bill had been allowed to come to the floor. A couple of years later, many of the same provisions, I would say most of the same provisions, were contained in the Kassebaum-Kennedy bill which was enacted into law, but the American people would have had those reforms available to them 2 years earlier under the aforementioned Rowland-Bilirakis bill.

As our task force worked on the Patient Protection Act, I believed it was necessary to include provisions on health access to the uninsured as well as those who are insured. After all, we

have to ask ourselves what good is insurance if one does not have access to basic medical care? Both expanded care for the uninsured and increased patient protections were accomplished, as others have already said I think, in the Patient Protection Act without, without imposing burdensome government mandates.

One principle way our bill expanded health access was by broadening the role of community health centers. Currently there are 42 million uninsured individuals in the United States. Our bill made it easier for community health centers to offer health care to those in medically underserved areas. H.R. 4250 would have saved money because patients would have used more efficient forms of care.

The bill also created community health organizations which are managed care plans controlled by community health centers. H.R. 4250 eliminated state requirements preventing community health organizations from participating in the health market.

H.R. 4250 also encouraged more competition in order to lower prices for health consumers. Community health centers would have had more money because they would have had more private paying patients using their facilities, and, as a result, these health centers would have provided care to even more uninsured people.

In addition, the Patient Protection Act also created important new safeguards which have been mentioned previously and gave patients greater access to high quality health care. The bill included a provision that enabled employers to pull together in health marts, a voluntary choice market where small employers could have obtained low cost and high quality coverage through the fully insured market. Of course the Patient Protection Act also included, as we have already said so many times, important new patient protections.

For months people across the country told Congress that they wanted to choose their own doctors. Well, we listened to our constituents. In fact, through our bill patients were guaranteed their choice of medical providers.

We also made it easier for patients to determine what their health plans covered. People would have actually understood their health care policies because descriptions would have been written in plain English.

Mr. Speaker, again Congress had a great opportunity to follow through with its commitment to reform health care in our country, and I challenge those that support patient rights to put people ahead of politics and agree to work with us instead of against us. Next year we must continue our fight for the uninsured. They deserve access to health insurance, and we will not stop until we achieve this goal, and in addition we must help those who want to choose their own doctors instead of allowing their insurance companies to choose their doctors for them. People want their personal health evaluated by someone who they can trust, and I feel it is our responsibility as Members of Congress to move forward in order to make this goal a reality for all Americans.

And finally, Mr. Speaker, I want to personally thank both you and Congressman DENNY HASTERT and of course all of the members of the task force with whom it was such a pleasure to work for their leadership in this issue. Both of you, both the Speaker and Mr. HASTERT, have done a tremendous job in bringing health reform before the House of Representatives this year. I will continue to be supportive of your efforts during the 106th Congress.

Mr. TALENT. Mr. Speaker, I appreciate the gentleman's comments, as always, about this bill which would have expanded the reach of private health insurance to millions of people who currently do not have it and then help to guarantee that those who do have health insurance get the care they need when they need it, when their physician recommends it and done that without big government. It was a good bill. It is a shame we could have closed ranks behind it.

Mr. Speaker, nobody did more to fight for this bill and to fight for the interests of people who currently do not have health insurance than the gentleman I am pleased to yield to next, the gentleman from Illinois (Mr. FAWELL), and I just want to say about him that he has fought tirelessly year after year after year to make association health plans a reality, he has talked to small business people, he talked to employees of small business people and he knows that patient protections are not worth anything if you do not have health insurance, as the gentleman says. And so it is a pleasure to yield to him for such comments as he might wish to make.

Mr. FAWELL. Mr. Speaker, I thank the gentleman very much, and I do want to commence my remarks by lauding Chairman HASTERT who brought a tremendous group of, yes, Republican Members of the House together, all of whom had varying degrees of experience in health care, and they worked, they have worked so hard, and they came up with a bill that I think the Patient Protection Act was a very fine piece of legislation. Unfortunately so much has happened. The President's problems and other matters have come along, and we have not had the light shine upon this legislation to bring forward its many, many good parts to which reference, a lot of references have already been made.

I think that the expansion that we were talking about here of the ERISA statute, for instance, so that small businesses can have the very same advantages that unions and large businesses have had for many, many years to be able to give to small businesses the ability to be able to band together into multiple-employer health care plans and so that they can have the economies of scale so they can do what the large businesses and unions can do. And what the large businesses and unions can do is they can, because they have the economies of scale, they can self-insure, and when they can self-insure, Mr. Speaker, that means that they have the ability to use clout and be able to bargain with health care providers or be able to bargain, for instance, with indemnity insurance companies and HMOs to bring the price down and to demand that there be the highest possible quality that can be given to their employees.

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This ERISA statute is often misunderstood, but it enables employers who are, by the way, not pro-health care provider nor pro-insurance company. They are pro-consumer. They are pro and for the employees of their company. And the large corporations all across America utilize this ERISA statute to have some very innovative and creative legislation.

In fact, it covers about 132 million people who get their health care from employer provided ERISA health care plans. And this legislation was simply suggesting that because the 43 million people in America who do not have health care are largely people who live in homes where the breadwinner is employed by small businesses or is self-employed, where obviously they do not have the economies of scale of large businesses or large unions, that this legislation suggested the very elementary idea that, why not allow small businesses to also band together multiple employer health care plans under association health care plans, which would be churches, associations, the Boys Club of America, for instance, farm groups, the National Chamber of Commerce, any number of business associations which are solid people, they are interested in their members. And why not let them therefore sponsor these associations, and therefore they too would have the ability because they have the numbers to be able to self-insure and to be able to have the ability to talk to health care providers and to bring the price of health care down, and that is what managed care is all about, and be able to also deal with indemnity insurance companies, the regular indemnity insurance companies, and be able to experience rates, for instance, on the basis of their particular smaller employers and employees.

That is what large corporations do. I think that is why most people who are employed by large corporations do have good solid health care coverage, and with a lot of choices too. That is awfully important. That means they have fee-for-service choices and things of that sort, which we would like to see occur.

As it is right now, the 43 million people, of course, have to go out into the individual market and, one by one, they do not have the economies of

scale, they do not have the clout and the ability to do what larger corporations can do.

So this legislation, for instance, that is just one part of this legislation. It is an idea whose time is long past due. I will not see it come to fruition, but people like the gentleman from Missouri (Mr. TALENT), the gentleman from Georgia (Mr. NORWOOD), and so many of the other fine people, the gentleman from Pennsylvania (Mr. GOODLING), the gentleman from Virginia (Mr. BLILEY), the gentleman from California (Mr. THOMAS), the gentleman from Florida (Mr. BILIRAKIS), the gentleman from Ohio (Mr. HOBSON), the gentleman from Florida (Mr. GOSS), the gentlewoman from Texas (Ms. GRANGER) and the gentlewoman from New York (Mrs. KELLY), I hope I have not missed anybody, but these are all-stars. These are people who really worked on this, and I feel the only sad part of it is they did not get this legislation to be really allowed to blossom.

Mr. TALENT. The gentleman's comments are very kind. I just have to say it is the gentleman's efforts year after year that have brought this to the floor and I hope bring it to fruition next year.

It comes down to this: If you are an employee of, let us say the Boeing Company, and Boeing has a very important division in my district with a former McDonnell Douglas company, with tens and tens of thousands of people working for them, it is a great company, so that company is big enough and has this huge group of people and the group is an efficient group and they can put out money and sell funds, so in effect they do not have an insurance company except maybe to administer different aspects of the plan. As a result, they can stay in control, they can provide the kind of coverage that their employees want, and they have these kinds of economies of scale.

Is not the whole issue why should not small employers be able to band together as groups to offer the same thing to their employees? They want to do it, their employees want it. There are tens of millions of people who do not have private health insurance. Why should they not be able to do that? Can you think of a reason?

Mr. FAWELL. No, I certainly cannot, except I suppose one might say that those who may be out there now serving this small business community do not want the competition, and I can understand that.

Mr. TALENT. That is the other question. Who was it that opposed this provision? Let us be up front about it. Was it not the insurance company who opposed this provision?

Mr. FAWELL. They did not agree with our view of the legislation. Yes, that is quite true. But the time has come where I have tried to point out the 43 million people who have to go out into the regular indemnity insurance market, for instance, which is, by the way, under state jurisdiction, are really anti-selected. Forty-three million cannot get health care.

We have to do something about it. If we do not do something about it, I would suggest that the private market is going to get a real black mark and somebody is going to talk about let us go back to the Clinton plan or something like that, when we do have the ability to be able to do something about it.

I wish you folks well in the next session of Congress. I shall be rooting for the team. I hope you get the same team together. And the gentleman from Illinois (Chairman HASTERT), I cannot say enough for him, because he sat there meeting after meeting after meeting. You know how many hours we worked, how many days we worked on this. And we had a great work product.

Unfortunately, the day that I think that that was passed, another event of terrible magnitude here occurred, a shooting and murder of two fine policemen, and then, after that, the President had his troubles, and I think the news media never even looked at this legislation very much as a result of this.

But it will pass eventually. It has to pass, because it is good legislation. I thank the gentlemen for their time.

Mr. TALENT. I thank the gentleman for his comments.

Mr. Speaker, it is curious that this bill was opposed in this House and the other body by people on the grounds that it was too nice to insurance companies and they opposed the provisions in it that the insurance companies were fighting, and that can only happen in Washington. Unfortunately, it happened here.

I am happy to yield to the gentleman from Georgia, whose efforts it is I think quite correct to say are the reason why this bill, a bill on this issue, was before the House. He has labored long and hard and against opposition sometimes from a lot of different quarters, and he has it here, and there is nobody I respect more and nobody who worked harder on behalf of patients. I yield to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, I thank the gentleman for his comments. I, too, enjoyed the 300 hours we spent on our task force trying to hammer out a patient protections bill. I thought in the few minutes I have to talk, I would like to talk about the history and how we got to really where we are at the end of the 105th Congress.

Much of this started many years ago, 1973 when Congress passed an HMO act, 1974, when Congress passed an ERISA act. And then we come up to 1995, and it was Republicans that dropped the health care bill. It was the Republicans who dropped a bill to bring to the attention of the 104th and 105th Congress that there were problems in managed care. People were being denied treatment, people were being rationed treatment, people were not being able to choose their own doctors. And, over the last three years, it has been Republicans who have said we have to deal with some of these issues.

Now I would like to just focus in on maybe two things. It is the two things I think about health care reform right now that are most important, and it has to do with principles like freedom, freedom to choose your own doctor. It has to do with principles, such as being responsible for the decisions you make.

When I go home in my district, I see a lot of political ads out there about HMOs that simply are not correct. They are being played, in my view, by people who do not quite understand what is going on.

But one of those issues and the one that probably has been the most contentious is about liability. I think everybody in America should know today, even though the Federal law, ERISA, preempts any state law, in other words, public policy at the state level no longer takes effect, and even though Federal law through ERISA is very solid on public policy regarding health care, it does at least say this: A patient has the right today, without us passing any legislation, to sue their insurance company or their HMO if their benefits are denied. You can do that today.

Now, the beauty of what this bill does, this task force bill, is it improves that so that it works. This is all under contract law. It allows people to actually be able to sue for their benefits, because if you win that benefit after going through an external review, then you cannot only win the cost of the benefit, but you can win the cost of going to Federal Court. That is extremely important, because that has denied people their due process because of the $25,000 or $30,000 it took to go to court to win the value of a $2,000 benefit. Basically nobody could go. We corrected that in the House task force bill.

In addition to that, if you have been denied care in a very untimely manner, then you have the possibility of winning up to $250,000 appointed by the judge. Now, this is very, very important, because all of these court cases are before bodily harm or death occurs. That is when you need the health care.

A mother wants their child treated. A mother does not want to go to court necessarily and win $1 million in punitive damages because their child died. Now, that is the beauty of the health task force bill.

I had a bill known as Patient Access to Responsible Care, PARC, and in that bill we were trying to give the patients the right to sue their HMO at the state level through tort law, through malpractice. I still believe that is a very good way to go, because what it does for these health care accountants, it makes them think twice before they turn to the mother and say, ''I know your pediatrician wants to have your child hospitalized, but I am the accountant and I say no.'' Then should bodily harm or death occur, that accountant should be held responsible for that decision in a state court of law.

Now, unfortunately, I could not win that debate. In January of this year, as I was pushing my bill, I was the only one willing to say that. I pleaded with the White House to add that kind of language in their Patients' Bill of Rights. I pleaded with the White House to add that to the State of the Union. I actually found out that the Democrat leadership was against that. The original Kennedy–Dingell bill didn't have that in it. In fact, one of my good friends in Congress on the other side of the aisle would not cosponsor my bill because it had it in it.

I find it very curious that today, that is the very thing that the Democrats decided to fall on their sword about and keep those in the Senate from putting out a good piece of legislation.

The other part of our bill, the task force bill, and my bill, PARC, that is extremely important, in my opinion, is to allow people to choose their own doctor. This is America, is it not? Why should we not have as much freedom as they do in England?

Now, our bill, for the first time, had what is known as a point of service provision in it that opened the door to allow the American people to choose their own doctor. But maybe even more importantly in this task force bill, that was not in mine, I wish it had been, was improving on medical savings accounts.

That is the greatest freedom there is in health care. I am very proud to be part of a task force that made possible medical savings accounts for those all over the country.

In conclusion, let me just say that what we hear today in the political ads is exactly what has killed health care reform in the 105th Congress. It is people who were more willing and more wishful of having votes than they were of protecting patients. That is exactly what the Democratic Senate did. They wanted to win votes on this issue, rather than opening the door and for the first time having some national public policy regarding health care.

I am going to join with my friend the gentleman from Missouri (Mr. TALENT) and the gentleman from Illinois (Mr. FAWELL), who will not be here, but the gentleman from Florida (Mr. BILIRAKIS) and others, and we are going to start again and keep on, and we are going to keep on and keep on until we give the patients of this country what they deserve, and that is the right to choose their own doctor and ask people who make decisions about your health care and tell people that you have to be responsible.

Mr. TALENT. I thank the gentleman for his comments.

I know I am close to being out of time, Mr. Speaker. I will just repeat again, we had a good bill. It would have provided the people the care they need, when they need it, when their physician recommends it, without big government and a lot of lawyers' fees.

As the gentleman from Georgia said, we will be back with it. I am confident we will have success. It is what the American people want. It is the best thing we could have done in the 30 years since the Congress passed Medicare.

□ 1730

THE OMNIBUS BILL: WHERE IS IT, WHAT DOES IT CONTAIN, WHO IS WRITING IT, AND WHEN WILL MEMBERS GET A CHANCE TO SEE IT?

The SPEAKER pro tempore (Mr. HANSEN). Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, do we remember the movie Roger and Me, where producer Roger Moore attempted to find Roger Smith, the President of General Motors? He looked everywhere for him. He looked in Detroit, he looked in Boca Raton. He could not find him, as Roger dutifully avoided the camera lens.

In Congress this month and last, we are producing a sequel to Roger and Me. It is called the Omnibus and Me. Let me ask, where is the omnibus bill? We know it is a large bill. We know we cannot find it. We know it is looking more and more like one of those dreaded congressional Christmas tree bills. No one seems to know in which room it is being written. No one knows exactly who is writing it. In fact, we are told three or four staffers are actually in charge. So who exactly are these unelected people? Where can Members go to read the bill?

Most importantly, Members do not know what is in the bill. We are told one-third of $1 billion is being slipped in to bail out poultry traders, get this, in Russia. That issue never came up during House consideration of the agricultural appropriation bill, which passed here overwhelmingly. It never came up in the Senate, either.

According to Sect. 201(f) of the Agricultural Trade Act of 1978; ''The Commodity Credit Corporation may not make export sales financing authorized under this section available in connection with sales of an agricultural commodity to any country that the Secretary determines cannot adequately service the debt associated with such sale.'' Currently, Russia is ineligible for the program.

So why is regular order being violated for certain special interests who can gain access to the corridors of this Congress very late in the year?

In fact, every piece of legislative business not completed during this Congress, now famous as the do-nothing Congress, the 105th Congress, is now being put on the table as bargaining chips among a very few players. Why? Because this Chamber and the other have not completed their business on time. The fiscal year began October 1. Everything happening here in Congress is being played actually in overtime, simply because every single congressional deadline under regular order has been missed by the group in charge.

What about the budget? There is no approved budget resolution for 1999, the fiscal year. We are already into that year. Some Committee on the Budget Members in leadership positions here in the House want to run for president, but they have not even completed the responsibilities of their committee work here in the House.

Look at the appropriation bills. A majority of them, eight of 13, have not been completed on time. Now they are being picked apart by a very few folks around here, without the sunlight of regular order and regular committee oversight.

Why is Congress here in October, at the end of a fiscal year? There is no budget. A majority of appropriation bills for fiscal year 1999, which has already begun, are not completed, a majority. Congress is operating in a stop-start knee-jerk operation actually not worthy of those that we represent.

For the record, let me point out again, there is no completed budget for the fiscal year we are already in because Congress did not finish its legislative business by passing its 13 appropriation bills by September 30.

On September 25 the first continuing resolution was offered that extended the congressional session 14 days overtime, as a handful of Members began drafting the omnibus bill that I have been looking for for several days. They are doing so in secret. Members, find the room and tell me where all this is being done.

Then, when they still did not finish after 2 more weeks, a second continuing resolution passed the House on October 9. They said they needed 4 more days to add more to the Christmas tree bill. That did not work, so then a third continuing resolution was offered on October 12, Columbus Day, somewhat historic, I suppose, for 2 more days, until October 14. Now today, a fourth overtime resolution was offered for 3 more days until Friday, the end of this week, October 16.

I sure would not put those manipulating this hit and miss scheduling in charge of anything after this Congress is over.

So I ask, where is the omnibus Christmas tree appropriation bill? Where can Members read it? Where, more importantly, can the public read it? Is it going to be put on the Internet, so the American people can read it before we have to vote on it, whenever that is?

I would say to Members, and I have been here a few years, I can tell Members with absolute certainty, if Members are not able to read this bill before it comes to the floor, Members have only one choice: Vote no.

TRIBUTE AND A THANK YOU TO KEITH PUTNAM, A HERO FROM HANAHAN, SOUTH CAROLINA

The SPEAKER pro tempore (Mrs. MYRICK). Under a previous order of the