it fought for civil rights and justice, maybe we will stand in this body and also answer the call for equal justice. We will pass real campaign finance reform, and we will have a tobacco bill that will protect our children. I hope that their call is not in vain and that it will not be silenced by the pondering of our voices and by the overwhelming special interests that try to strangle democracy in this House.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Florida (Ms. ROS-LEHTINEN) is recognized for 5 minutes.

(Ms. ROS-LEHTINEN addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

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

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

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

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

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

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

U.S. SUPPORT FOR PEACE AND STABILITY IN THE CAUCASUS

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

Mr. PALLONE. Mr. Speaker, yesterday two of my colleagues, Mr. KENNEDY of Massachusetts and Mr. KENNEDY of Rhode Island and I met with Deputy Secretary of State Strobe Talbot and other top State Department officials to discuss the resolution of the conflict in Nagorno Karabagh, a state in the southern Caucasus region of the former Soviet Union. Our goal was to try to develop some new ideas on how we can work to promote greater cooperation and stability in this strategically-located region.

Although the State Department clearly considers Nagorno Karabagh to be of the utmost importance, my colleagues and I are concerned the U.S. diplomatic efforts have either stalled or are going in the wrong direction. We are concerned that our diplomatic priorities are being eclipsed by commercial interests in the region and that the traditional American mission of promoting democracy is being diverted by the desire to develop oil resources.

Secretary Talbot and his colleagues from the Department of State who met with us were most gracious, I should say, but there are differences between the State Department and those of us in this Congress who are staunch supporters of Armenia and Nagorno Karabagh.

And, Mr. Speaker, as I have mentioned in this House on several occasions, the people of Nagorno Karabagh fought and won a war of independence from Azerbaijan. A tenuous ceasefire has been in place since 1994, but a more lasting settlement has been elusive. The United States has been involved in a major way in the negotiations intended to produce a just and lasting peace. Our country is a co-chair along with France and Russia of the international negotiating group commonly known as the Minsk group formed to seek a solution to the Nagorno Karaagh conflict. Pro Armenian Members of this House welcome the high profile U.S. role in this process. As I have indicated, we have some substantive differences.

Unfortunately the State Department is most reluctant to drop its support for Azerbaijan's claim of so-called territorial integrity despite the fact that Nagorno Karabagh has been inhabited by Armenians for centuries.

□ 2230

I would say, Mr. Speaker, it is time for the U.S. and our Minsk Group partners to forget about the idea of Azerbaijan's so-called ''territorial integrity'' as the foundation for peacefully resolving this conflict.

In the first place, given Nagorno Karabagh's autonomous status in the old Soviet system, there is no reason why they must be considered part of Azerbaijan. But more importantly, Mr. Speaker, the people of Nagorno Karabagh do not consider themselves to be a part of Azerbaijani society. And, considering the horrible treatment visited upon the people of Karabagh and the Armenian community in Azerbaijan proper, it is apparent to me that Azerbaijan really has no use for the people of Karabagh.

The State Department officials that we met with yesterday seemed to be open to new ideas coming from the parties to the conflict, and that created a certain amount of optimism. They stressed that if Armenia, Azerbaijan and Nagorno Karabagh all agreed on a status for Nagorno Karabagh that left it free of Azeri suzerainty, the United States would go along. There was a clear understanding on the part of the State Department that the earlier Minsk Group proposal that did not address the status issue was no longer acceptable to Armenia or Nagorno Karabagh.

Mr. Chairman, as we stressed at yesterday's meeting, our top priority should be to push for direct negotiations, involving Nagorno Karabagh and Azerbaijan, without preconditions. And I should add that any proposal that starts with the premise that the map of Azerbaijan must include Nagorno Karabagh is a big precondition.

As a first step, Mr. Speaker, I would stress the importance of strengthening the current, shaky cease-fire as a priority for the Minsk Group. Making a priority of securing the cease-fire would help end the violence, stop the continuing casualties, and help build confidence for further agreements between the parties.

I believe we should also consider the idea of ''horizontal links,'' a federation between Azerbaijan and Nagorno Karabagh among equals. This model has been used in resolving the Bosnia war and in the current negotiations aimed at resolving the Cyprus conflict.

Another key is the need for security guarantees for Karabaugh. As I mentioned, Karabagh won the war and holds the strategic advantage. But it is unrealistic and unfair to except Karabagh to give up its gains on the battlefield for vague promises at the negotiating table by the United States or the other Minsk Group cochairs.

Finally, let me say, Mr. Speaker, that America's role should be that of a nonbiased mediator. It is a role that we have played honorably and with great success in conflicts raging from the Middle East to Bosnia and to Northern Ireland, and there should be no difference here in the case of Karabagh.

POSSIBLE CURES FOR ABUSES IN MANAGED CARE

The SPEAKER pro tempore (Mr. HAYWORTH). Under the Speaker's announced policy of January 7, 1997, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, it has been a long day here in the House with a lot of debate about campaign finance reform, and as our colleagues on the other side of the Capitol have been debating for almost 4 weeks until it ended yesterday, a debate on tobacco legislation, which appears to be at least significantly set back. We have a debate going on on campaign finance reform which is much needed, and it appears as if we may have a 3 or 4 week debate on that as well. I hope that the outcome comes out better than that.

But I want to speak tonight about another issue that has been bottled up in Congress for a couple of years that has broad bipartisan support, something that is very important to our constituents back home and to every American, and that is the issue of abuses in managed care and whether we ought to have some minimum standards, Federal safety standards for managed care.

I frequently hear my colleagues who oppose this saying, well, let us not legislate by anecdote. I mean, heaven forbid that we should ever in this body legislate by anecdote. The problem is that these anecdotes are real people, and they are all over the country, and

we can read about them in newspapers at home, and nearly everyone knows somebody or has a family member that has been affected by abuses in the managed care industry.

Here we have a headline from the New York Post: ''HMO's Cruel Rules Leave Her Dying for the Doc She Needs.'' Does that seem harsh? Well, how about this case history of one of these ''anecdotes.'' Although I really do not think we would want to call Barbara Garvey an anecdote to her family.

Barbara Garvey is a 54-year-old Chicago woman who fell seriously ill when she was vacationing in Hawaii. The doctors in Hawaii correctly diagnosed her condition and advised the Garveys that she needed a bone marrow transplant immediately. Then the physicians cautioned the couple that Barbara should not travel back to Chicago for this treatment since this could increase the risk of her suffering a cerebral hemorrhage, or infection during her air travel. So they phoned her doctor back in Chicago who agreed with the Hawaiian doctors; take care of her in Hawaii. Travel by an airplane in her condition is too dangerous. However, the HMO bureaucrats told Barbara's husband, David, that the HMO would not be responsible for her treatment if she remained in Hawaii, and that she should return to Chicago. In route to Chicago, Barbara suffered a stroke that left her right side paralyzed and she was unable to speak. When she arrived in Chicago, she was admitted to St. Luke's Medical Center where she died 9 days later of a stroke.

The HMO then attempted to use a legal loophole to avoid all responsibility. That loophole is contained in a law known as the Employee Retirement Insurance Security Act of 1974, ERISA, which was enacted well before the era of managed care and was intended to provide workers with benefit protections. The HMO claims that because Garvey received her health care through her employer, the Garveys cannot receive damages for Barbara's death.

HMOs have been using ERISA, in many cases successfully, to shield them from the accountability of their decisions, when they tie the doctor's hands and they direct a patient's care leading to injury, or even, in the case of Barbara Garvey, death.

Well, I guess the opponents to this legislation would just say, gee, we should not legislate by anecdote.

Well, how about the case of Betty Wolfson. This is told by her daughter. The dispute between my mother and her HMO arose when the HMO's doctors recommended a course of treatment that world-renowned neurosurgeons at UCLA medical centers believe will endanger her life. We wanted a second opinion because my mom has an artery in her brain the diameter of a golf ball that is full of blood clots. It has caused her to go blind in one eye. At any time she could completely lose her sight and suffer a massive stroke, or die.

Initially my mom's HMO stated there is no appeal process. Finally, someone explained there was no ''complaint department,'' only a ''customer satisfaction department.'' By the sheer fact that HMOs have endless financial resources, her daughter continues, this makes it a cinch for her HMO to prevail. When this process bankrupts my mother and forces my folks out of their HMO, it is often taxpayers that end up picking up the tab, saving the HMO from having to shell out for expensive medical treatments.

Her daughter continues, Sadly, our story is not unique. ERISA, the Employment Retirement Income Security Act, contains a loophole that allows HMOs to sidestep accountability for denying or delaying medical care. If this loophole were closed now, families like ours would not have to suffer financial and emotional ruin to get adequate help for our loved ones.

Mr. PALLONE. Mr. Speaker, will the gentleman yield?

Mr. GANSKE. I yield to the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, first of all, let me say that I am very pleased to see the gentleman here again tonight talking about the need for managed care reform or patient protections, because I believe, as I have said before, that this is the number one issue facing this Congress. It is the issue that I hear most often when I talk to my constituents and our constituents throughout this country, be they Democrat, Republican, Independent; regardless of party affiliation, regardless of State, are demanding action on these patient protections.

I just wanted to make a brief comment which is that the gentleman really points out how this is nothing more than a very common sense approach to quality health care. The gentleman mentioned anecdotes, and of course they are not, they are real people and we know that they are real people, but beyond that is the notion that, and I have said this before, in my constituents' minds and I think most Americans' minds, when they hear the types of things that the gentleman is relating, they cannot believe it because they assume that their insurance company, whether it is an HMO or whatever kind of managed organization, would follow common sense precepts. In other words, they would not assume that because one is in Hawaii that one has to take a plane contrary to one's health and come back to Chicago.

They would not assume, for example, that if one needs to go to an emergency room, that one would have to go to one 40 miles away rather than the one that is around the corner, because that particular hospital is not part of the network. They assume that if someone has to have access to a particular type of care, specialty care, for example, that the specialist is going to be available and that the HMO will not deny them.

I think even more so, as the gentleman pointed out, is that when I talk to some of my constituents that have had problems with HMOs, they talk about the lack of an appeals process that they can really utilize, because again, if a mother has to take care of a sick child or a father has to take care of a sick child and they are working, they do not have the time to spend 9 hours a day going through some obscure way of appealing a decision. They have to have a very easy way to take an appeal to someone who is actually going to hear it in an expedited way.

I have found, as the gentleman said, that a lot of these problems with HMOs, essentially what happens is that if someone does not want to accept a decision that has been made with regard to a particular type of care or access to a specialist or use of particular equipment, that people essentially give up because they do not have the time or the wherewithal to go through the appeals process, and that should not be. That is what is so egregious I think about the system that is set up.

Of course, the other aspect that the gentleman points out is the inability to sue the HMO when they make a mistake or they make a decision that actually damages someone or kills someone. Again, I do not think most people would think that they have lost the right to sue because of the Federal law that is out there.

So all we are really saying, all the gentleman is really saying is that we need some common sense patient protections that apply to all HMOs, to all managed care organizations, to all insurance companies, and that those basic patient protections, that ''floor,'' if you will, needs to be put in place. Otherwise, we have people dying and people getting seriously ill, and the long-term consequences of that not only are bad for the individuals, but in many cases cost the taxpayers even more money because they end up footing the bill.

So I just want to thank the gentleman again for these examples, because I think that when we use examples, that is the way people will understand it. But unfortunately, we are going to have to somehow get this into the heads of some of our colleagues, because although there are a lot of people that support this, there are a lot unfortunately that make it difficult to bring up the legislation.

Mr. GANSKE. Mr. Speaker, reclaiming my time, I appreciate the gentleman's comments, because he is getting to a point that I will get to a little bit later, but we might as well get to now. I am going to talk about some more examples tonight, but it is not as if we have not had several bipartisan bills sitting here in Congress this year, last year, bipartisan bills in 1996 with over 300 cosponsors dealing with this problem with no standards for people who are in HMOs and are receiving their insurance through their employer in a self-insured plan because of Federal law.

□ 2245

We have two bipartisan bills now, right here sitting here in Congress waiting to be acted on. One is the Patient Bill of Rights. The other is the Patient Access to Responsible Care Act.

The second one has about 230 cosponsors. Just by the number of cosponsors alone, if it were on the floor today it would pass. I happen to think that when and if we can get one of these bills to the floor, and overcome the leadership's objections to this legislation, that legislation will pass overwhelmingly in a bipartisan fashion.

But why is it being held up? What is the problem? I mean, it is not as if the American public is not calling for this. It is not as if the American public is not well aware of these problems, which I will going to go into in more detail. Nine out of ten Americans by survey today say: Please, give us some Federal legislation for some minimum quality standards so that when we get sick, our HMO will give us the care that we need.

Mr. PALLONE. Mr. Speaker, if the gentleman would yield, I think it is pretty obvious. And I do not think we need to do any more than ask the average American. I am sure they would articulate and be right in saying that it is the insurance industry, of course, that is continuing to lobby in Congress to prevent this legislation from coming forward.

The fact of the matter is they spend a lot of money on advertisements and other ways of trying to influence what goes on here. So I have no doubt that the reason why the leadership has been unwilling to bring this to the floor is because of the opposition from the insurance industry.

We have had this so often with health care reform in general. But this, of course, hits at the very heart of the HMO and the managed care industry, because they fear that somehow by us putting these patient protections in effect, that they are going to be told what to do or that somehow their costs may be impacted.

I really do not see it as a cost issue. I do not think it is going to cost anything more, or certainly a very insignificant amount extra money if anything, to implement these basic patient protections and we have to keep making that point.

Mr. GANSKE. Mr. Speaker, reclaiming my time for a moment, I think we should make a distinction between the insurance industry and HMOs and the managed care industry.

There are a lot of health insurance companies that provide health insurance policies to individuals. They do not have the liability exemption that a managed care plan, an HMO, has when it is offered through an employer. Consequently, we see significantly fewer of these horror stories from that portion of the insurance industry.

We see fewer reports of problems in the nonprofit managed care industry because they are ethically trying to do their job. When they look at a Patient Bill of Rights, as has been proposed by our legislation, they are already doing most of the things that we are proposing.

What we are really talking about is a subset of the managed care industry that adamantly opposes quality standards. Why? Because they are cutting corners. That way they can increase their profit margin. Their stock will go up. Their CEOs will make millions more. They can capture more of the market share, because they are keeping their premiums lower than those plans that are actually trying to do a legitimate job.

Mr. PALLONE. Mr. Speaker, if the gentleman will yield, we had a report that the gentleman mentioned the other night on the floor about the CEOs of some of these for-profit HMOs or managed care organizations, their salaries are many millions of dollars per year with all kinds of stock options that add up to additional millions of dollars.

I am glad the gentleman brought out the distinction between the different types of HMOs and managed care, because in fact many of the not-for-profit HMOs or managed care organizations in the beginning, when the President first proposed patient protections, were actually supportive of the patient protections, most of which are incorporated in the two bipartisan bills that the gentleman mentioned.

It is true that there are good and bad insurance companies and generally the not-for-profit HMOs and managed care organizations have not really had a problem with the kind of patient protections that we are talking about.

Mr. GANSKE. We are actually seeing some of the nonprofit HMOs such as Kaiser, HIP, calling for Federal legislation for patient protections. They would like to see a national uniform standard so that their competitors who cut corners and needlessly put at risk people's life and limbs are not able to unfairly compete against them when they are trying to do a legitimate job.

Let me give another example. I am not calling some of these cases anecdotes, because some of the opponents to these two bills say, well, we should not legislate by anecdote. I am a physician. I continue to be a physician. I continue to do charity care while I am in Congress. So I am going to refer henceforth in this talk tonight to ''patients,'' because that is what I think they are.

Let us talk about Francesca Tenconi, an 11-year-old girl. She suffers from a disease called Pemphigus Foliaceous. This is an autoimmune disease in which her body's immune system becomes overactive and attacks the protein in her skin.

Her parents have had to battle with their HMO to insist upon appropriate diagnosis and medical care. According to her father, Francesca's medical and insurance ordeal began in December 1995 when at the age of 11 she was diagnosed with a skin rash. By March, that condition had spread and become worse, and by April it was so bad she could not attend school. During this period, her parents made several requests to get a referral to a specialist to find out what was going on and her HMO refused.

Finally, in May, almost 6 months after the first appearance of her skin problems, the HMO finally did some biopsies and sent them to out-of-network doctors and they finally got an accurate diagnosis. But even after receiving the diagnosis, her HMO still insisted on treating the disease with its own doctors, even though this is a very complicated, difficult disease.

It was not until February of 1997, over 1 year after her symptoms appeared, that they finally allowed her to receive care at Stanford Medical Center, which possessed the doctors capable of treating this illness.

Explaining the prolonged and unnecessary pain of lying down without skin on his daughter's back for over a year, Don Tenconi 6 said, ''If you feel this pain, you will shed tears of pain. The same pain that Francesca shed night after night, week after week for months.''

And because Francesca received her health care through Donald's employer, the HMO claims that ERISA shields it from damages resulting from delaying and denying medically appropriate care and referrals. And that is wrong.

That is a real live little girl who for a year had basically no skin on her back. Think of how painful that condition would be. Think about being that little girl's mother and father. Think about their continued appeals to try to get appropriate care from their managed care company.

Today in our committee, the Committee on Commerce, we had a long hearing on liver transplants. Let me give another example of an HMO abuse. A woman suffering, her name is Judith Packevicz, suffering from a rare form of cancer of the liver, is today being denied life-saving treatment by her HMO. The HMO will not pay for a liver transplant recommended by her oncologist, with the support of all of her treating physicians.

This is causing this woman to live out a death sentence. The HMO denied the recommended transplant on the grounds that it allegedly ''does not meet the medical standard of care for this diagnosis.''

No explanation of why the recommended transplant allegedly fails to meet community standards, when all of her doctors have recommended this treatment, has been provided in correspondence from the HMO.

Well, under ERISA, should Mrs. Packevicz die before she receives a transplant, her HMO will have no costs at all. Is that what we want to see continue in this country?

Mr. PALLONE. Mr. Speaker, that is horrible. Can I ask the gentleman if he

knows, what would be the cost of a liver transplant, approximately? What is the cost? Do you have any idea?

Mr. GANSKE. The cost of a liver transplant, in total, would probably be in the range of several hundred thousand dollars. This is not something that the Packevicz can afford.

Mr. PALLONE. But this is obviously the reason why they are excluding it, because they do not want to incur that cost. There is no question, I would say.

Mr. GANSKE. Mr. Speaker, what we have with the managed care industry is we have a situation where they make more profit by giving less service, less treatment. By my mind, this is the only industry in this United States or anywhere where they get paid more for doing less. It is a perverse incentive system and one that needs guidelines so that it is not abused.

Another example, how about Carol Anderson, a hospital worker who has had to change insurance providers in the middle of her breast cancer treatment. When she called an HMO to ask if her doctors were on his network of physicians, she was told they were not but because her breast reconstruction was already underway, she could stay with them.

However, the next month, that HMO refused to cover her surgery claiming she had been misinformed by somebody and so after months of fighting, they finally agreed to pay, but only if she switched physicians. That is tough in the middle of treatment, especially reconstructive treatment. I am a reconstructive surgeon. I know how difficult some of those operations can be.

The bills that are sitting here waiting to be acted upon by Congress address that. They say that if a patient is in the middle of treatment and the employer switches the insurance coverage to a different HMO, the patient does not have to switch doctors until that treatment is finished.

Same thing goes with pregnancy. A woman is 7-months pregnant, her employer switches plans, her current doctor is not in the treatment plan. Well, too bad. She has to go to a new physician, a new doctor. Our bills address that and say, huh-uh, if employees are offerer an employer plan in that situation with a pregnant woman nearly ready to give birth, they cannot force her to go to another physician. And why? Because there is a certain benefit to continuity of care.

Mr. PALLONE. Mr. Speaker, if the gentleman would again yield, just common sense. We are not really asking for anything more. And obviously it makes sense to not switch physicians in the middle of a pregnancy or in the middle of some kind of disorder.

If I could just mention too, I think that many constituents that I talk to, not only in my district but in other parts of the country, really would like to see some kind of option where patients can go outside the network for a doctor or hospital or other provider, even if it means that the patient has to pay more.

I know that the Patient Bill of Rights, which is one of the bills that the gentleman mentioned, specifically says that when consumers sign up for health insurance with the employer, that the employer has to offer the option of going outside the network for a doctor, even if it means that the patient has to pay a little more. Not everybody wants to do that, but for those people who are willing to pay a little more it certainly makes sense.

I find that a lot of people do not realize when they sign up for a particular HMO that they are limited by the number of doctors, or realize what doctors are in the plan or not. That is why disclosure, which is another one of the issues that is addressed in these two bills, is so important.

We need to have disclosed what the patient is getting into when they sign up. Too many people now just do not know what the HMO covers and what it does not, and what doctors are in it and what hospitals are in it and what not.

☐ 2300

That is another basic right and another basic protection that those bills address which I think needs to be addressed.

Mr. GANSKE. Mr. Chairman, in light of all of these cases, and I can come to the floor every single night and talk about patients like these, and the gentleman could, too. In light of that, what does the American public think about all of this? Let me give a few of the findings from a nationwide health care poll done by a Republican pollster, the Republican pollster, by the way, who did most of the polling for the Contract With America.

Let us just look at what some of the findings were in this recently conducted poll of over 1,000 adults nationwide. This was done May 1, 1998.

Question: Would you say the overall quality of health care over the last 10 years has improved, stayed the same, or deteriorated? Improved, 34 percent; stayed the same, 15 percent; deteriorated, 46 percent.

Fifty-five percent of Americans living in the West think the overall quality of care has deteriorated in the last 10 years.

Question: Health care providers should be required to give their patients full information about their treatment, their condition, and treatment options. Do you support? Support, 7 percent; opposed, 1.6 percent.

There is a provision in one of these bills, allow free communications, allow unrestricted communications between doctors and their patients. We would think that would be a given right.

Mr. PALLONE. Mr. Chairman, I think the gentleman should elaborate on that a little bit more. Most people are shocked by this gag rule. Just explain that a little more. People are shocked when they hear what kinds of restrictions are in place.

Mr. GANSKE. Mr. Chairman, as the gentleman from New Jersey knows, I have had a bill before Congress with over 300 bipartisan cosponsors that my Republican leadership will not allow to the floor. It would ban gag clauses which prevent doctors from being able to tell their patients all of their treatment options. We are not saying the HMO has to cover all of those treatment options; we are simply saying that the HMO cannot restrict a physician from telling a patient all of their treatment options. That is what those gag clauses are. I cannot even get that to the floor.

Mr. PALLONE. I would wonder whether or not that is even constitutional if someone ever wanted to take it up to the Supreme Court. It seems to violate the First Amendment not to be able to speak out in your profession.

Mr. GANSKE. Mr. Chairman, let us go on with some of these survey findings.

Proposal: Any basic managed care plan would be required to allow patients to see plan specialists when necessary. Do you support? 94 percent. Opposed, 2.1 percent.

We are talking about the ability when you have a complicated medical decision to get a referral to a specialist. That is one of the provisions in these two bills: the Patient Bill of Rights and the Patient Access to Responsible Care Act. Ninety-five percent of the American public agrees with that.

Proposal: Patient should have the right to a speedy appeal when a plan denies coverage for a benefit or service. Do you support? 94.7 percent. Opposed, 3.3 percent.

Proposal: A complete list of benefits and costs offered by the health plan before he or she signs up for the plan. Do you support? 91.3 percent. Opposed, 4.6 percent.

This is another one of the provisions that is in both of these bills, full disclosure. For heaven's sake, we are talking about an organization that makes life and death decisions.

Proposal: All health plans must allow their patient the option of seeking treatment outside of their HMO with the HMO covering at least a portion of the cost. Do you support? 87 percent. Opposed, 8.8 percent.

It goes across all groups. Here is another one. Insurance companies would be prohibited from paying doctors more money for offering less treatment or refusing referrals. Do you support? By a margin of two to one across all age groups, Republicans, Democrats, rich, poor.

Question: Let us say the proposals I just read were packaged in a single piece of legislation. Would you be more likely or less likely to vote for your Member of Congress if he or she voted for this legislation? More likely, 86 percent; less likely, 4 percent.

Here is a very interesting question from this Republican pollster. This, I think, gets to what we want to talk about next, and that is cost. If you knew that enacting all six proposals as

a single piece of legislation would cost about $17 more per month, would you support this legislation? Support, 67 percent; oppose, 23 percent.

Do you know what? That is way higher than most of the estimates done by reputable accounting firms would say would be the cost. A survey by Coopers & Lybrand done by the Kaiser Family asked the question or looked at it actuarially. What would be the cost of a Patient Bill of Rights?

Mr. PALLONE. Most of what I have seen are within $5 and $10. That is most of what I have seen.

Mr. GANSKE. Coopers & Lybrand said that a cost of the legislation, Patient Bill of Rights, exclusive of the liability provision, and we will get to that in a minute, would cost a family of four for a year $31.

Mr. PALLONE. Which is a lot less.

Mr. GANSKE. Significantly less than the question, which had a two-thirds majority positive answer.

We often hear from the opponents to this, well, small business is really against this. All of those small businesses would stop covering their employees. It would mean that more and more people would not have insurance.

Okay. This is very interesting, because today, actually yesterday, Kaiser Family, Kaiser-Harvard Program at the Public and Health Social Policy Institute, the Kaiser Family Foundation released a survey done of 800 small business people across the country. So these are the employers, these are the small business employers.

What did they find? They found that small business executives are pretty much just like everyone else in the public. They think that there is a need for Federal legislation on this.

Let me provide some specifics. Questions to the small business executives, the ones who are providing the insurance to the majority of people in this country: Would you favor a law requiring health plans to provide more information about how they operate? 89 percent favored; 5 percent opposed.

Would you favor a law requiring health plans to require ability to appeal health plans decisions? 88 percent favored; 8 percent opposed.

They continue to ask these small business executives: Would you favor a law requiring plans to allow direct access to gynecologists? 84 percent favored.

Would you favor a law requiring health plans to allow direct access to specialists? 75 percent favored.

Would you favor a law requiring health plans to remove limits on coverage for emergency room visits, so that if you have a case of crushing chest pain, you can go to the emergency room and not be worried that if the EKG is normal, you are going to be stuck with a big bill? 77 percent favored.

Mr. PALLONE. But, again, if the gentleman will yield, it makes sense that we get these kinds of responses because it is just common sense. Why would people think anything different? That is, I think, what we have been saying from the beginning, that these are just common-sense principles, and people are going to overwhelmingly support them.

But I just wanted to mention two other things that the gentleman brought up, and I would like to stress again; and those are, the reason why people are demanding these changes and want these bills to come to the floor is because the quality of health care is suffering.

We have prided ourselves in this country for so many years on having the best quality health care in the world, and I would venture to say that we still do, but that will not be the case for very long unless we start to put these kinds of common-sense protections in place, because quality is really suffering, and people realize that more and more. I think that people are used to having quality health care in this country, and they are not going to be satisfied with something less than that.

The other thing that the gentleman mentioned is that the opponents not only talk about cost, but suggest that because of the exorbitant costs that they bring up falsely, that the consequence of our legislation would be that fewer people would have health insurance. In fact, there is no truth to that whatsoever.

In fact, the reality is that fewer and fewer Americans have health insurance every day even with the HMOs in place. The phenomenon of more and more Americans not having health insurance is not a consequence of HMOs or any particular type of health insurance. It has to do with the fact that more and more employers simply do not provide health insurance. That is the biggest factor. So, really that is a ruse, talking about the costs. Talking about the fact that fewer Americans have health care has nothing to do with this debate, nothing to do with it whatsoever.

Mr. GANSKE. Mr. Chairman, reclaiming my time, this Kaiser Family Foundation survey gets right to that point. They asked these employers: How many of you will drop your coverage for your employee? The answer was between 1 and 3 percent; 1 and 3 percent, significantly different from the inflated claims that you will hear from the business groups.

But I want to point out a couple of additional things in this survey, and this is very interesting. Small business executives were asked this: Would you be in favor of requiring health plans by law to allow patients to sue health plans? This is going to surprise some of my colleagues on the Republican side. Favor, 61 percent; oppose, 30 percent.

If you then ask the question: Would you still be in favor of it if it resulted in higher premiums? More than half still favor it. Why? It is just like this talk I gave to this group of businesswomen, small businesswomen back in my district about a month ago.

We were talking about this issue. Do you know why? Because they are also consumers. They know that if their son or daughter has a skin problem like we have talked about with this poor little girl who is 11, and they have problems, they need to have recourse and remedy for it.

Then they went back, and they asked all those other questions that I have talked about by saying: Would you still favor that law if it might result in higher premiums? And 60 percent or more still favored every one of those.

Then they found this: 57 percent of small business executives think that managed care has made it harder for people who are sick to see medical specialists; 58 percent say it has decreased the quality of care people receive when they are sick; 65 percent of these small business executives say it has reduced the amount of time doctors spend with our patients; and interestingly, 43 percent say it really has not made much of a difference of what my health care costs have been to have all of my employees in an HMO.

I think that when we look at really some of our grass-roots, small business people, the people who are purchasing that insurance for their 10, 15, 20 employees, they are just like everyone else in the public. They know that there are abuses in those health plans, and they want to make sure, darn sure that their employees are not harmed, and also that they and their families who are covered by their plans are not harmed.

Mr. PALLONE. The employers are usually covered by the same plan.

Mr. GANSKE. Exactly.

Mr. PALLONE. It only makes sense.

Mr. GANSKE. Let us talk for a minute about the cost of liability. We have heard a lot of inflated estimates of this. Texas, as you know, passed a liability provision taking away the exemption for HMOs in Texas.

☐ 2315

So one of the HMOs asked its actuarial firm how much extra should they raise the cost of a premium, and they asked the actuarial firm that is in the pockets of the HMOs, the one that does all the HMOs' bidding, Milliman & Robertson, well outlined by an expose, I would say, in the Wall Street Journal just recently. Even so, when Milliman & Robertson had to put the number on the line for the company that was actually going to do this, the liability provision would have raised the cost of the premium, I think, 0.3 percent. No, I am sorry, 34 cents per month, 34 cents per month.

Mr. PALLONE. Could I ask the gentleman this? The bottom line is that if we have this liability provision, and the HMOs know that they could be liable, I would think the consequence would be that they would be a lot more careful about what they deny and what they do. And so, therefore, the situations where they would be liable for malpractice or making the wrong decisions would decrease and their costs probably would not be that great.

So a lot of this is just preventive. A lot of the things that we are suggesting here just make for a better system in general and create prevention on the part of the HMO. And so I think that that is the reason why ultimately the cost is not really going to go up.

Mr. GANSKE. Well, let us look at a little more detail at this. This is going to be a matter of contentious debate, if and when we can ever get the Republican leadership to allow this to come to the floor, and that is, what will be the cost of the liability on this?

Well, here is what we have. We have a study that was done by Multinational Business Services, MBS. They estimated the liability cost impact of insurance premiums would be 0.75 percent. Less than 1 percent. What did Muse & Associates find would be the cost of liability for HMOs? 0.14 percent to 0.2 percent, two-tenths of a percent. How about the Barents Group? What did they estimate? 0.9 percent, less than 1 percent, up to about 1.5 percent.

But, really, as was pointed out, the insurance premium increases are most likely to occur for the HMOs that are most likely to be denying the care that is medically necessary, not the HMOs that are trying to do the ethical job that they should be and providing the care when it is medically appropriate. So there would be a range.

For many plans that are trying to do the ethical thing, the costs would be minimal.

Mr. PALLONE. And we would be bringing the unethical ones up to the same standards as the ethical ones in the long run. That is what the effect would be.

Mr. GANSKE. I remember in our Committee on Commerce we had testimony by a medical reviewer. Her name was Linda Peno. She testified before our committee, and she admitted that she killed a man. She was not in prison, she was not on parole, she had never been even investigated by the police. In fact, for causing the death of a man, she received congratulations from her colleagues and moved up the corporate ladder.

She was working as a medical reviewer at an HMO. She confessed how HMOs can use the term ''medically necessary'' as the ''smart, smart bomb'' of denials. There is a lot we need to do in terms of due process and making sure that HMOs do not abuse some of the terms that they use all the time to deny care; that is, in both of these bills, Patient Access Responsible Care Act and Patient Bill of Rights.

And there are standard due process provisions in those bills so that if care is denied, a patient can get a timely appeal process. Gee, that does not sound so outlandish. That is something that every other insurance company that is not shielded by ERISA has found it has had to do for 40 or 50 years, or else they would suffer the consequences.

□ 2320

When we talk about this legislation, I liken this to the automobile industry. When my colleagues or I buy a car, we are assured that we are going to have a car with headlights that work, turn signals, brakes, safety seat belt, some minimum federal safety standards. And yet, I do not see that we have any nationalized auto industry. And judging from the ads that I see in magazines or on TV, there sure is an awful lot of competition out there in the auto industry.

But we have some Federal standards, do we not?

Mr. PALLONE. Absolutely.

Mr. GANSKE. What is wrong with having some minimum safety standards for plans that Congress 25 years ago give a total exemption to?

Mr. PALLONE. There is no question that this is nothing more than common sense. We have said it over and over again and we are simply asking for a floor for patient protections.

I think, as the gentleman has well pointed out this evening, that basically it just brings the standards, if you will, of some of the worse for-profit HMOs up to the level of some of the better not-for-profit HMOs.

I just want to say once again that, really, the key here is not to persuade I think the average congressman or congresswoman. Because, as my colleague has said, we have a majority of the Members of this House on one or both of these bills. What we have to do is persuade the leadership that this is something that needs to be brought up.

I think tonight, with the polling that you brought out, makes a very convincing case and, hopefully, will also convince the leadership that from a political point of view this makes sense. Because the gentleman has very specifically pointed out how this is something that the public is going to be watching in terms of how they vote in November.

So, hopefully, we are lighting up a fire here tonight when we continue to bring up this issue. And although there are not a lot of days left in this session, there is certainly enough to get this passed.

I want to commend the gentleman again for being outspoken on this issue. Of course, as a physician, he is in the best position really to talk about these cases and analyze some of them. And I commend him, as a physician and as a Member of this body, for speaking out even though it is often at odds with his own leadership.

Again, I do not want to make this a partisan issue because I believe that most Members of this body, whether Republican or Democrat, support this legislation. So I think we just have to keep at it and keep telling these stories and keep pointing out to our colleagues how important it is that this be brought of up before we end the session this fall.

Mr. GANSKE. Reclaiming my time, I would just think that our constituents ought to consider real people who are affected by some of the horror stories that we are hearing from mismanaged care.

Let me give my colleague another example. We recently had a 28-year-old woman who was hiking in the Shenandoah Mountains not too far from here. She fell off a 40-foot cliff accidentally. Luckily, she was not killed. She had a fractured skull, was comatose, broken arm, broken pelvis, was lying at the bottom of this 40-foot cliff, nearly drowned in a nearby pool.

Fortunately, she had a hiking companion, was able to get a life flight, was taken to a hospital, spent a long time in the hospital, ICU, morphine drips, all sorts of things. Her HMO refused to pay for her hospitalization.

This is that woman, Jackie Lee, shortly before she was put onto the helicopter. The HMO refused to pay for her care because she had not phoned for a preauthorization, as they would say.

I ask my colleagues, Jackie Lee was lying there at the base of that have 40-foot cliff, comatose, with a broken arm and pelvis, and a fractured skull. Was she supposed to wake up with her noninjured arm, pull her cellular phone out of her pocket, dial a number probably thousands of miles away to get an okay to go to the hospital?

And then after she was at the hospital, the HMO said, well, you did not notify us in time so we are not going to pay you on that reason also. Well, my goodness gracious, she was comatose in the ICU for a week. She was on intravenous morphine.

That is the type of real-life problem that all of those small business employers who answered this survey are aware of. They are aware of it either from their own families or friends or they are aware of it from their employees. That is why they are calling on Congress, just like everyone else, to do something.

I will just have to finish on this.

Mr. PALLONE. Before my colleague finishes, though, again, I assume that the cost of this care that she received was very expensive and that is another reason why they are denying it.

Mr. GANSKE. Reclaiming my time, I can guarantee my colleague that this young woman did not have the $12,000 to $15,000 that her HMO refused to pay. And neither would most people in this country.

So, I think that I would encourage all of our constituents from around the country to rise up in arms on this, to say, look, Congress may have killed tobacco legislation that would help prevent youngsters from smoking, maybe they are going to obfuscate on campaign finance reform. But I will tell my colleagues, there is one thing that Congress had darn well better do before it leaves because my daughter or my son's health may depend on it or my mother's or fathers's or my employees', and that is Congress needs to fix the mess that it has made in the past related to health plans and managed care.

If Congress does not handle this problem, we are going to hold you personally, congressman or congresswoman,

responsible for doing this and we will hold the leadership responsible.

I will tell my colleagues, I am hearing from all over the country on this. The water is building up behind this dam on this issue. And I will just have to say that sometimes it takes remarkable actions to get the leadership of this House and the Senate to do what they ought to do for the betterment of our constituents. We very well may be looking at that in the very near future.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mrs. CLAYTON (at the request of Mr. GEPHARDT) for today after 3 p.m., on account of official business.

Mr. GREEN (at the request of Mr. GEPHARDT) for today and the balance of the week, on account of official business in the district.

Mr. REYES (at the request of Mr. GEPHARDT) for today and the balance of the week, on account of official business.

Mr. SUNUNU (at the request of Mr. ARMEY) for today after 4 p.m. And the balance of the week, on account of attending a wedding in the family.

Mr. WELDON of Florida (at the request of Mr. ARMEY) for today and on June 19 and 22, on account of family matters.

Mr. GUTKNECHT (at the request of Mr. ARMEY) for today after 1:30 p.m. And the balance of the week, on account of attending his son's graduation.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. MEEHAN) to revise and extend their remarks and include extraneous material:)

Mr. CONYERS, for 5 minutes, today.

Mr. DAVIS of Illinois, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

Mr. POMEROY, for 5 minutes, today.

(The following Members (at the request of Mr. SHAYS) to revise and extend their remarks and include extraneous material:)

Mr. MILLER of Florida, for 5 minutes, on June 22.

Mr. SCARBOROUGH, for 5 minutes, today.

Mr. METCALF, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. MEEHAN) and to include extraneous material:)

Mr. VENTO.

Mr. KIND.

Mr. HAMILTON.

Mr. FROST.

Mr. FORD.

Mr. DINGELL.

Mr. SANDLIN.

Mr. ROTHMAN.

Mr. ACKERMAN.

Mr. MCGOVERN.

Mr. LAFALCE.

Ms. LEE.

Mr. DAVIS of Florida.

Mr. BENTSEN.

Mr. STARK.

Ms. NORTON.

Mr. NEAL of Massachusetts.

Mr. LIPINSKI.

Mr. KUCINICH.

Mr. VISCLOSKY.

Mr. CONYERS.

(The following Members (at the request of Mr. SHAYS) and to include extraneous material:)

Mr. FRELINGHUYSEN.

Mr. WOLF.

Mr. DAVIS of Virginia.

Mr. GILMAN.

Mr. RADANOVICH.

Mr. DUNCAN.

Mr. PORTER.

Mr. YOUNG of Alaska.

Mr. PACKARD.

BILLS PRESENTED TO THE PRESIDENT

Mr. THOMAS, from the Committee on House Oversight, reported that that committee did on this day present to the President, for his approval, bills of the House of the following title:

H.R. 1847. An act to improve the criminal law relating to fraud against consumers.

H.R. 3811. An act to establish felony violations for the failure to pay legal child support obligations, and for other purposes.

ADJOURNMENT

Mr. GANSKE. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 28 minutes p.m.), the House adjourned until tomorrow, Friday, June 19, 1998, at 9 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

9680. A letter from the General Counsel, Department of Defense, transmitting a report entitled ''Department of Defense Panel to Study Military Justice in the National Guard Not in Federal Service,'' pursuant to Public Law 104—201, 110 Stat. 2534; to the Committee on National Security.

9681. A letter from the Director, Office of Rulemaking Coordination, Department of Energy, transmitting the Department's final rule—Conduct of Employees (RIN: 1990–AA19) received June 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

9682. A letter from the Director, Office of Rulemaking Coordination, Department of Energy, transmitting the Department's final rule—Information Security Program [DOE O 471.2A] received June 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

9683. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Implementation of Section 402(b)(1)(A) of the Telecommunications Act of 1996 [CC Docket No. 96–187] received June 17, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

9684. A letter from the Secretary of Health and Human Services, transmitting a draft of proposed legislation to amend titles XIX and XXI of the Social Security Act to achieve improvements in outreach and provision of health care to children; to the Committee on Commerce.

9685. A letter from the Chief, Regulations Branch, U.S. Customs Service, transmitting the Service's final rule—Emissions Standards For Imported Nonroad Engines [T.D. 98–50] (RIN: 1515–AC28) received May 22, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

9686. A letter from the Chief Counsel, Office of Foreign Assets Control, Department of the Treasury, transmitting the Department's final rule—Blocked Persons, Specially Designated Nationals, Specially Designated Terrorists, and Specially Designated Narcotics Traffickers: Additional Designations [31 CFR Chapter V] received May 27, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on International Relations.

9687. A letter from the Assistant Secretary for Strategy and Threat Reduction, Department of Defense, transmitting the joint Department of Defense and Department of Energy report to Congress on the Project Plan for the Russian Reactor Care Conversion Program, pursuant to Pub.L. 105—29; to the Committee on International Relations.

9688. A letter from the Executive Director, Committee for Purchase From People Who Are Blind or Severely Disabled, transmitting the Committee's final rule—Procurement List Additions—received June 17, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform and Oversight.

9689. A letter from the Acting Assistant Secretary for Fish and Wildlife and Parks, Department of the Interior, transmitting a draft of proposed legislation to amend the Act which established the Weir Farm National Historic Site, in the State of Connecticut, by modifying the boundary and for other purposes; to the Committee on Resources.

9690. A letter from the Assistant Administrator, National Ocean Service, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Monterey Bay National Marine Sanctuary [Docket No. 971014243–7243–01] received June 17, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

9691. A letter from the Assistant Administrator, National Ocean Service, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Temporary Rule Prohibiting Anchoring by Vessels 50 Meters or Greater in Length on Tortugas Bank within the Florida Keys National Marine Sanctuary [Docket No. 971014245–7245–01] received June 17, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

9692. A letter from the Deputy Assistant Administrator for Fisheries, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule—Taking of Marine Mammals Incidental to Commercial Fishing Operations; Pacific Offshore Cetacean Take Reduction Plan Regulations [Docket No. 970129015–7220–05; I.D. 010397A] (RIN: 0648–AI84) received June 17,