1st Session; the New York and New Jersey Harbor Entrance Channels and Anchorage Areas, published as Senate Document 45, 84th Congress, 1st Session; and the New York Harbor, NY Anchorage Channel, published as House Document 18, 71st Congress, 2nd Session, as well as other related reports with a view to determining the feasibility of environmental restoration and protection relating to water resources and sediment quality within the New York and New Jersey Port District, including but not limited to, creation, enhancement and restoration of aquatic, wetland, and adjacent upland habitats.

Adopted: April 15, 1999.

Attest: Bud Shuster, Chairman.

RESOLUTION—DOCKET 2597—UPPER MISSISSIPPI RIVER FROM LAKE ITASCA TO LOCK AND DAM 2, MINNESOTA

Resolved by the Committee on Transportation and Infrastructure of the United States House of Representatives, That the Secretary of the Army is requested to review the report of the Chief of Engineers on the Mississippi River above Coon Rapids Dam near Minneapolis, Minnesota, published as House Document 66, 73rd Congress, 1st Session, and other pertinent reports with a view to determining whether modifications of the recommendations contained therein are advisable at this time in the interest of flood damage reduction, environmental restoration and protection, water quality and other purposes, with a special emphasis on determining the advisability of developing a comprehensive coordinated watershed management plan for the development, conservation, and utilization of water and related land resources in the Upper Mississippi River Basin from the Mississippi's headwaters to Lock and Dam #2 at Hastings, Minnesota.

Adopted: April 15, 1999.

Attest: Bud Shuster, Chairman

There was no objection.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The Speaker pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, May 11, 1999.

Hon. J. DENNIS HASTERT,
The Speaker, House of Representatives, Washington, DC.

DEAR MR. SPEAKER, Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, I have the honor to transmit a sealed envelope received from the White House on May 10, 1999 at 5:40 p.m., and said to contain a message from the President whereby he submits a certification pursuant to Section 1512 of Public Law 105–251.

With best wishes, I am

Sincerely,

JEFF TRANDAHL,
Clerk.

CERTIFICATION REGARDING EXPORT OF SATELLITE FUELS TO CHINA—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 106–60)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committees on Armed Services and the Committee on International Relations and ordered to be printed:

To the Congress of the United States:

In accordance with the provisions of section 1512 of Public Law 105–261, the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, I hereby certify that the export to the People's Republic of China of satellite fuels and separation systems for the U.S.-origin Iridium commercial communications satellite program:

(1) is not detrimental to the United States space launch industry; and

(2) the material and equipment, including any indirect technical benefit that could be derived from such export, will not measurably improve the missile or space launch capabilities of the People's Republic of China.

WILLIAM J. CLINTON.

THE WHITE HOUSE, *May 10, 1999.*

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain special order speeches without prejudice to the resumption of legislative business.

ON HEALTH CARE

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

Mr. GANSKE. Mr. Speaker, I have taken to the well of this Chamber many times to talk about the need to enact meaningful patient protection legislation. Unfortunately, there remains a compelling need for Federal action, and I am far from alone in holding that view.

Last week, for example, Paul Elwood gave a speech at Harvard University on health care quality. Elwood isn't exactly a household name, but he is considered the father of the HMO movement.

Elwood told a startled group that he did not think health care quality would improve without government-imposed protections. Market forces, he told the group, ''will never work to improve quality, nor will voluntary efforts by doctors and health plans.''

Mr. Elwood went on to say, and I quote, ''It doesn't make any difference how powerful you are or how much you know. Patients get atrocious care and can do very little about it. I've increasingly felt we've got to shift the power to the patient. I'm mad, in part because I've learned that terrible care can happen to anyone.''

This is a quote by Paul Elwood, the father of the American HMO movement. Mr. Speaker, this is not the commentary of a mother whose child was injured by her HMO's refusal to authorize care. It is not the statement of a doctor who could not get requested treatment for a patient. Mr. Speaker, these words suggesting that consumers need real patient protection legislation to protect them from HMO abuses come from the father of managed care.

Mr. Speaker, I am tempted to stop here and to let Dr. Elwood's speaks for themselves, but I think it is important to give my colleagues an understanding of the flaws in the health care market that led Dr. Elwood to reach his conclusion.

Cases involving patients who lose their limbs or even their lives are not isolated examples. They are not anecdotes.

In the past, I have spoken on this floor about little Jimmy Adams, a 6-month-old infant who lost both hands and both feet when his mother's health plan made them drive many miles to go to an authorized emergency room rather than stopping at the emergency room which was closest.

The May 4 USA Today contains an excellent editorial on that subject. It is entitled, Patients Face Big Bills as Insurers Deny Emergency Claims.

After citing a similar case involving a Seattle woman, USA Today made some telling observations:

''Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford.''

Or, ''All patients are put at risk if hospitals facing uncertainty about payment are forced to cut back on medical care.''

This is hardly an isolated problem. The Medicare Rights Center in New York reported that 10 percent of complaints about Medicare HMOs related to denials for emergency room bills.

The editorial noted that about half the States have enacted a ''prudent layperson'' definition for emergency care this decade, and Congress has passed such legislation for Medicare and Medicaid.

Nevertheless, the USA Today editorial concludes that this patchwork of laws would be much strengthened by passage of a national prudent layperson standard.

The final sentence of the editorial reads, ''Patients in distress should not have to worry about getting socked with big health bills by firms looking only at their bottom line.''

Mr. Speaker, I include the full text of the editorial in the RECORD at this point.

[From USA Today]

TODAY'S DEBATE: PAYING FOR EMERGENCY CARE—PATIENTS FACE BIG BILLS AS INSURERS DENY EMERGENCY CLAIMS

Our View—Industry Promises to Fix the Problem Fail, Investigations Begin

Early last year, a Seattle woman began suffering chest pains and numbness while driving. The pain was so severe that she pulled into a fire station seeking help, only to be whisked to the nearest hospital, where she was promptly admitted.

To most that would seem a prudent course of action. Not to her health plan. It denied payment because she didn't call the plan first to get ''pre-authorized,'' according to an investigation by the Washington state insurance commissioner.

The incident is typical of the innumerable bureaucratic hassles patients confront as HMOs and other managed care companies attempt to control costs. But denial of payment for emergency care presents a particularly dangerous double whammy:

Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford.

All patients are put at risk if hospitals, facing uncertainty about payment, are forced to cut back on medical care.

Confronted with similar outrages a few years ago, the industry promised to clean up its act voluntarily, and it does by and large pay up for emergency care more readily than it did a few years ago. In Pennsylvania, for instance, denials dropped to 18.6% last year from 22% in 1996.

That's progress, but not nearly enough. Several state insurance commissioners have been hit with complaints about health plans trying to weasel out of paying for emergency room visits that most people would agree are reasonable—even states that mandate such payments. Examples:

Washington's insurance commissioner sampled claims in early 1998 and concluded in an April report that four top insurers blatantly violated its law requiring plans to pay for ER care. Two-thirds of the denials by the biggest carrier in the state—Regence BlueShield—were illegal, the state charged, as were the majority of three other plans' denials. The plans say those figures are grossly inflated.

The Maryland Insurance Administration is looking into complaints that large portions of denials in the state are illegal. In a case reported to the state, an insurance company denied payment for a 67-year-old woman complaining of chest pain and breathing problems because it was ''not an emergency.''

Florida recently began an extensive audit of the state's 35 HMOs after getting thousands of complaints, almost all involving denials or delays in paying claims, including those for emergency treatments.

A report from the New York-based Medicare Rights Center released last fall found that almost 10% of those who called the center's hotline complained of HMO denials for emergency room bills.

ER doctors in California complain the Medicaid-sponsored health plans routinely fail to pay for ER care, despite state and federal requirement to do so. Other states have received similar reports, and the California state Senate is considering a measure to toughen rules against this practice.

The industry has good reason to keep a close eye on emergency room use. Too many patients use the ER for basic health care when a much cheaper doctor's visit would suffice.

But what's needed to address that is better patient education about when ER visits are justified and better access to primary care for those who've long had no choice other than the ER, not egregious denials for people with a good reason to seek emergency care.

Since the early 1990s, more than two dozen states have tried to staunch that practice with ''prudent laypersons'' rules. The idea is that if a person has reason to think his condition requires immediate medical attention, health plans in the state are required to pay for the emergency care. Those same rules now apply for health plans contracting with Medicare and Medicaid.

A national prudent layperson law covering all health plans would help fill in the gaps left by this patchwork of state and federal rules.

At the very least, however, the industry should live up to its own advertised standards on payments for emergency care. patients in distress should not have to worry about getting socked with big health bills by firms looking only at their own bottom line.

Mr. Speaker, there are few people in this country who have not personally had a difficult time getting health care from an HMO. Whether we are talking about extreme cases like James Adams or the routine difficulties obtaining care that seem all too common, the public is getting frustrated by managed care. The HMO industry has earned a reputation with the public that is so bad that only tobacco companies are held in lower esteem.

Let me cite a few statistics to back this up. Mr. Speaker, by more than two to one, Americans support more government regulation of HMOs. Last month, the Harris Poll revealed that only 34 percent of Americans think that managed care companies do a good job of serving their customers. That is down sharply from the 45 percent who thought so just a year ago.

Maybe more amazing were the results when Americans were asked whether they trusted a company to do the right thing if they had a serious problem. By nearly a two to one margin, Americans would not trust HMOs in such a situation. That level of confidence was far behind other industries, such as hospitals, airlines, banks, automobile manufacturers and pharmaceutical companies. In fact, the only industry to fare worse in the survey than HMOs were tobacco companies.

Anyone who still needs proof that managed care reform is popular with the public just needs to go to the movie, As Good As It Gets. Audiences clapped and cheered when during the movie Academy Award winner Helen Hunt expressed an expletive about the lack of care her asthmatic son was getting from their HMO. No doubt the audience's reaction was fueled by dozens of articles and news stories highly critical of managed care and also by real-life experiences.

□ 1545

In September 1997 the Des Moines Register ran an op-ed piece entitled, ''The Chilly Bedside Manner of HMOs,'' by Robert Reno, a Newsweek writer.

The New York Post ran a week-long series on managed care. The headlines included ''HMO's Cruel Rules Leave Her Dying for the Doc She Needs.''

Another headline blared out: ''Ex New Yorker Is Told: Get Castrated So We Can Save Dollars.''

Or how about this headline? ''What His Parents Didn't Know About HMOs May Have Killed This Baby.''

Or how about the 29-year-old cancer patient whose HMO would not pay for his treatments? Instead the HMO case manager told him to have a fund-raiser. A fund-raiser. Mr. Speaker, I certainly hope that campaign finance reform will not stymie this man's attempts to get his cancer treatment.

To counteract this, this image in the public, even some health plans have taken to bashing their colleagues. Here in Washington one ad declared, ''We don't put unreasonable restrictions on our doctors, we don't tell them they can't send you to a specialist.''

In Chicago Blue Cross ads proclaimed, ''We want to be your health plan, not your doctor.''

In Baltimore an ad for Preferred Health Network assured customers: ''At your average health plan cost controls are regulated by administrators. At PHN doctors are responsible for controlling costs.''

Mr. Speaker, advertisements like these demonstrate that even the HMOs know that there are more than a few rotten apples in the barrel.

An example of this problem can be found in the recent 10th Circuit Court of Appeals decision in the case Jones v. Kodak. The name Jones is particularly appropriate because after this decision other health plans will rush to keep up with what their competitors are doing to the Joneses in this world. In Jones v. Kodak the 10th Circuit Court of Appeals showed how a clever health plan can use federal law to keep patients from getting needed medical care. The facts are relatively simple:

Mrs. Jones received health care through her employer, Kodak. The plan covers inpatient substance abuse treatment when medically necessary. The determination as to whether a particular substance abuse service is medically necessary is made by American Psych Management, APM.

Mr. Speaker, APM reviewed a request for inpatient substance abuse treatment and found that Mrs. Jones did not meet APM's protocol for inpatient mental health hospitalization. The family pursued the case further, eventually persuading the health plan to send the case to an independent medical expert for review. The reviewer agreed that Mrs. Jones did not qualify for the benefit under the criteria established by the plan. But the reviewer observed that, ''the criteria are too rigid and do not allow for individualization of case management.'' In other words, the criteria were not appropriate to Mrs. Jones' condition. His hands being tied, the reviewer was unable to reverse APM's original decision.

So Mrs. Jones sued for the failure to pay the claim. The trial court affirmed the court's decision to grant summary judgment to the defendants. The 10th Circuit Court of Appeals held the following:

''The Employment Retirement Income Security Act's disclosure provisions do not require that the plan's summary contained particularized criteria for determining medical necessity.''

The court went on.

''The unpublished APM criteria were part of the plan's terms. Because we

consider the APM criteria a matter of planned design and structure rather than implementation, we agree that a court cannot review them.''

Mr. Speaker, in layman's terms this means that a plan does not have to disclose the treatment guidelines or protocols it uses to determine whether or not a patient should get care. Moreover, any treatment guidelines used by the plan would be considered part of the plan design and thus are not reviewable by a court.

The implications of this decision, Mr. Speaker, are in a word ''breathtaking''. Jones v. Kodak provides a virtual road map to enterprising health plans on how to deny payment for medically necessary care. The decision is a clear indication of why we need Federal legislation to ensure that treatment decisions are based on good medical practice and take into consideration the individual patient's circumstances.

Under Jones v. Kodak, health plans do not need to disclose to potential or even current enrollees the specific criteria they use to determine whether a patient will get treatment. There is no requirement that a health plan uses guidelines that are applicable or appropriate to a particular patient's care.

Despite these limitations, Jones compels external reviewers to follow the plan's inappropriate treatment guidelines because to do otherwise would violate the sanctity of ERISA, and most important to the plan, the decision assures the HMOs that, if they are following their own criteria, then they are shielded from court review. It makes no difference how inappropriate or inflexible the criteria may be since, as the court in Jones noted, this is a plan design issue and, therefore, not reviewable under ERISA.

Mr. Speaker, if Congress through patient protection legislation does not act to address this issue, many more patients are going to be left with no care and no recourse to get that care. Jones v. Kodak sets a chilling precedent making health plans and the treatment protocols untouchable. The case in effect encourages health plans to concoct rigid and potentially unreasonable criteria for determining when a covered benefit is medically necessary. That way they can easily deny care and cut costs, all the while insulated from responsibility for the consequences of their actions.

Let me give my colleagues an example. A plan could promise to cover cleft lip surgery for those born with that birth defect. But they could then put in undisclosed documents that the procedure is only medically necessary once the child reaches the age of 16. Or that coronary bypass operations are only medically appropriate for those who have previously survived two heart attacks.

Mr. Speaker, you may think that sounds absurd, but that is the way the law reads. Logic and principles of good medical practice would dictate that that is not sound health care, but the Jones case affirms that health plans do not have to consider medicine at all. They can be content to consider only the bottom line.

Unless Federal legislation addresses this issue, patients will never be able to find out what criteria their health plan uses to provide care, and external reviewers who are bound by current law will be unable to pierce those policies and reach independent decisions about the medical necessity of a proposed treatment using clinical standards of care, and Federal ERISA law will prevent courts from engaging in such inquiries also. The long and the short of the matter is that sick patients will find themselves without proper treatment and without recourse.

Mr. Speaker, I have introduced legislation, H.R. 719, the Managed Care Reform Act, which addresses the very real problems in managed care. It gives patients meaningful protections. It creates a strong and independent external review process, and it removes the shield of ERISA which health plans have used to prevent State court negligence actions by enrollees who have been injured as a result of that plan's negligence.

This bill has received a great deal of support and has been endorsed by consumer groups like the Center For Patient Advocacy, the American Cancer Society, the National MS Society. It is also supported by many health care provider groups such as the American Academy of Family Physicians whose professionals are on the front lines and have seen how faceless HMO bureaucrats thousands of miles away, bureaucrats who have never seen the patient, can deny needed medical care because it does not fit their, quote, criteria unquote.

Mr. Speaker, I would like to focus on one small aspect of my bill, specifically the way in which it addresses the issue of the Employee Retirement Income Security Act, ERISA. It is alarming to me that ERISA combines a lack of effective regulation of health plans with a shield for health plans that largely gives them immunity from liability for their negligent decisions.

Personal responsibility has been a watch word for this Republican Congress, and this issue should be no different. Health plans that recklessly deny needed medical service should be made to answer for their conduct. Laws that shield entities from their responsibility only encourage them to cut corners. Congress created the ERISA loophole and Congress should fix it.

Mr. Speaker, my bill has a compromise on the issue of health plan liability. I continue to believe that health plans that make negligent medical decisions should be accountable for those decisions, but winning a lawsuit is little consolation to a family that has lost a loved one. The best HMO bill assures that health care is delivered when it is needed, and I also believe that the liability should attach to the entity that is making those medical decisions. Many self insured companies contract with large managed care plans to deliver care. If the business is not making those discretionary decisions, under my bill they would not face liability. But if they cross the line and they determine whether a particular treatment is medically necessary in a given case, then they are making medical decisions and they should be held responsible for their actions.

Now, Mr. Speaker, to encourage health plans to give patients the right care without having to go to court my bill provides for both an internal and an external appeals process that is binding on the plan, and an external review could be requested by either the patient or the health plan. I can see circumstances where a patient is requesting an obviously inappropriate treatment; let us say laetrile, and the plan would want to send the case to external review. The external review would back up their denial. It would give them, in effect, a defense if they are ever dragged into court.

When I was discussing this idea with the President of Wellmark Iowa Blue Cross/Blue Shield, he expressed support for the strong external review. In fact, he told me that his company is instituting most of the recommendations of the President's Commission on Health Care Quality and that he did not foresee any premium increases as a result. Mostly what it meant, he told me, was tightening existing safeguards and policies already in place.

Now, Mr. Speaker, this chief executive also told me that he could support a strong, independent, external review system like the one in my bill, but he cautioned: If we did not make the decision and are just following the recommendations of the review panel, then we should not be liable for punitive damages, and I agree with that. Punitive damages awards are to punish outrageous and malicious conduct. If a health plan follows a recommendation of an independent review board composed of medical experts, it is tough to figure out how they acted with malice. So my bill provides health plans with a complete shield from punitive damages if they follow the recommendation of that external review panel, and that I think is a fair compromise on this issue of health plan liability.

And I certainly suspect that Aetna wishes that they had had an independent peer panel available even with a binding decision on care when it denied care to David Goodrich. Earlier this year a California jury handed down a verdict of $116 million in punitive damages to his widow, Teresa Goodrich. If Aetna or the Goodriches had had ability to send the denial of care to external review, they could have avoided the courtroom. But more importantly, David Goodrich might still be alive today.

Mr. Speaker, that is why my plan should be attractive to both sides. Consumers get a reliable and quick external appeals process which will help

them get the care they need. But if the plan fails to follow the external reviewer's decision, the patient can sue for punitive damages, and health insurers whose greatest fear is that 50 or $100 million punitive damage award can shield themselves from those astronomical awards but only if they follow the recommendations of an independent review panel which is free to reach its own decision about what care is medically necessary.

□ 1600

The HMOs say that my legislation and other patient protection legislation would cause premiums to skyrocket. There is ample evidence, however, that that would not be the case.

Last year, the Congressional Budget Office estimated that a similar proposal, which did not include the punitive damages relief, would increase premiums around 4 percent over 10 years.

When Texas passed its own liability law 2 years ago, the Scott and White Health Plan estimated that premiums would have to increase just 34 cents per member per month to cover the costs. These are hardly alarming figures.

The low estimate by Scott and White seems accurate since only one suit has been filed against the Texas health plan since Texas passed patient protection legislation removing the liability shield. That is far from the flood of litigation that opponents predicted.

I have been encouraged by the positive response my bill has received, and I think that this could be the basis for a bipartisan bill this year. In fact, the Hartford Courant, a paper located in the heart of insurance country, ran a very supportive editorial on my bill by John MacDonald. Speaking of the punitive damages provision, MacDonald called it a reasonable compromise and urged insurance companies to embrace the proposal as, quote, the best deal they may see in a long time, unquote.

Mr. Speaker, I include the full text of the editorial by John MacDonald in the RECORD at this point.

[From the Hartford Courant, March 27, 1999]

A COMMON-SENSE COMPROMISE ON HEALTH CARE

(By John MacDonald)

U.S. Rep. Greg Ganske is a common-sense lawmaker who believes patients should have more rights in dealing with their health plans. He has credibility because he is a doctor who has seen the runaround patients sometimes experience when they need care. And he's an Iowa Republican, not someone likely to throw in with Congress' liberal left wing

For all those reasons, Ganske deserves to be heard when he says he has found a way to give patients more rights without exposing health plans to a flood of lawsuits that would drive up costs.

Gankse's proposal is included in a patients' bill of rights he has introduced in the House. Like several other bills awaiting action on Capitol Hill, Ganske's legislation would set up a review panel outside each health plan where patients could appeal if they were denied care. Patients could also take their appeals to court if they did not agree with the review panel.

But Ganske added a key provision designated to appeal to those concerned about an explosion of lawsuits. If a health plan followed the review panel's recommendation, it would be immune from punitive damage awards in disputes over a denial of care. The health plan also could appeal to the review panel if it thought a doctor was insisting on an untested or exotic treatment. Again, health plans that followed the review panel's decision would be shielded from punitive damage awards.

This seems like a reasonable compromise. Patients would have the protection of an independent third-party review and would maintain their right to go to court if that became necessary. Health plans that followed well-established standards of care—and they all insist they do—would be protected from cases such as the one that recently resulted in a $120.5 million verdict against an Aetna plan in California. Ganske, incidentally, calls that award ''outrageous.''

What is also outrageous is the reaction of the Health Benefits Coalition, a group of business organizations and health insurers that is lobbying against patients' rights in Congress. No sooner had Ganske put out this thoughtful proposal than the coalition issued a press release with the headline: Ganske Managed Care Reform Act—A Kennedy-Dingell Clone?

The headline referred to Sen. Edward M. Kennedy, D–Mass., and Rep. John D. Dingell, D–Mich., authors of a much tougher patients' rights proposal that contains no punitive damage protection for health plans.

The press release said: ''Ganske describes his new bill as an affordable, common sense approach to health care. In fact, it is neither: It increases health care costs at a time when families and businesses are facing the biggest hike in health care costs in seven years.''

There is no support in the press release for the claim of higher costs. What's more, the charge is undercut by a press release from the Business Roundtable, a key coalition member, that reveals that the Congressional Budget Office has not estimated the cost of Ganske's proposal. The budget office is the independent reviewer in disputes over the impact of legislative proposals.

So what's going on? Take a look at the coalition's record. Earlier this year, it said it was disappointed when Rep. Michael Bilirakis, R–Fla., introduced a modest patients' rights proposal. It said Sen. John H. Chafee, R–R.I., and several co-sponsors had introduced a ''far left'' proposal that contains many extreme measures. John Chafee, leftist? And, of course, it thinks the Kennedy-Dingell bill would be the end of health care as we know it.

The coalition is right to be concerned about costs. But the persistent No-No-No chorus coming from the group indicates it wants to pretend there is no problem when doctor-legislators and others know better.

This week, Ganske received an endorsement for his bill from the 88,000-member American Academy of Family Physicians. ''These are the doctors who have the most contact with managed care,'' Ganske said. ''They know intimately what needs to be done and what should not be done in legislation.''

Coalition members ought to take a second look. Ganske's proposal may be the best deal they see in a long time.

Mr. Speaker, it is also important to state what this bill does not do to ERISA plans. It does not eliminate the Employment Retirement Income Security Act or otherwise force large multistate health plans to meet benefit mandates of each and every of the 50 States. This is an exceedingly important point.

Just 2 weeks ago, representatives of a major employer from the upper Midwest were in my office. They urged me to rethink my legislation because they alleged it would force them to comply with benefit mandates of each State and that the resulting rise in costs would force them to discontinue offering health insurance to employees.

Frankly, Mr. Speaker, I was stunned by their comments, because their fears are totally unfounded. It is true that my bill would lower the shield of ERISA and allow plans to be held responsible for their negligence, but it would not alter the ability of group health plans to design their own benefits package.

Let me be absolutely clear on this point. The ERISA amendments in my bill would allow States to pass laws to hold health plans accountable for their actions. It would not allow States to subject ERISA plans to a variety of State benefit mandates.

Mr. Speaker, there are other pressing issues that require our prompt attention. In particular, the crisis in the Balkans is becoming a humanitarian tragedy of unspeakable proportions. No matter what else Congress does, we have to stand ready to help the displaced Kosovars with food, clothing and shelter.

Regardless of how the crisis in the Balkans evolves, it would be irresponsible for Congress to ignore domestic policy issues. The need for meaningful patient protection legislation continues to fester.

Before closing, Mr. Speaker, I also want to address something that should not be in patient protection legislation, and I am speaking specifically of extraneous provisions that could bog down the bill and severely weaken its chances for passage and for being signed into law.

In particular, there have been reports in the press and elsewhere that the managed care reform legislation will at some point be married with a bill to increase access to health insurance. Let me be perfectly clear on this. I strongly believe that Congress should consider ways to make health insurance more affordable. It would be a tremendous mistake, however, in my opinion, to try to marry these two ideas together. It would present too many opportunities for needed patient protections to become sidetracked in fights over tax policy and the future of the employer-based health system.

There are many reforms to improve access to health care that I support. I have long advocated medical savings accounts. In fact, Mr. Speaker, I wrote a white paper about their potential benefits in 1995 and was pleased to see them created first for small businesses and the uninsured and then 2 years ago for Medicare recipients.

I also support changing the law so individuals receive the same tax treatment as large businesses when buying

health insurance. It makes no sense to me why a big business and its employees can deduct the cost of health benefits but an employee of a small company that does not offer health insurance must pay all of the cost with after-tax dollars.

Finding the money to provide this tax equity is not going to be easy.

I believe that ideas like association health plans, also known as multiple employer welfare associations, MEWAs, and healthmarts could destroy the individual market by leaving it with a risk pool that is sicker and more expensive.

Let me give some specific concerns about association health plans or multiple employer welfare associations. Simply put, an association health plan is a pool of individuals who are employers who band together and form a group that self-insures. By doing so, they remove themselves from regulation by State insurance commissioners and instead subject themselves to regulation by Federal ERISA law.

While association health plans may provide a measure of efficiency for employers, they leave employees without any real safeguards against the less honorable practices of HMOs. In a very real sense, ERISA remains the Wild West of health care. Unlike State laws which regulate quality, ERISA contains only minimal safeguards for quality. Let me explain.

ERISA places only limited requirements on health plans. They must act as fiduciaries, meaning they must exercise sound management consistent with rules established by a plan sponsor. They must provide written notice to beneficiaries whose claims have been denied, setting forth the reasons. They must disclose some information about the plan to participants of beneficiaries. They cannot discriminate against beneficiaries. They have to allow certain employees, usually those who have been terminated, to purchase COBRA coverage. They have to provide coverage to adopted children in the same manner they cover natural children, and they have to comply with the 1996 HIPAA law in regards to portability.

That sounds all right, but consider what ERISA does not require. Among its many requirement shortcomings, ERISA does not impose any quality assurance standards or other standards for utilization review. ERISA does not allow consumers to recover compensatory or punitive damages if a court finds against the health plan in a claims dispute. ERISA does not prevent health plans from changing, reducing or terminating benefits; and with few exceptions ERISA does not regulate the design or content such as covered services or cost sharing of a plan. Remember from the Jones case how important that can be. And ERISA does not specify any requirements for maintaining plan solvency.

I confess, I cannot understand why some Members would want to place more employees in health plans regulated by ERISA. If anything, we should be moving in the opposite direction and returning regulatory authority to State insurance commissioners.

The patient protection legislation is intended to fix some very real problems in ERISA. I will not consider adding to the number of people under its regulatory umbrella until I see meaningful patient protections for them signed into law.

I am certainly not alone in my concerns about association health plans. When they were proposed as part of the Republican patient protection bill last year, they drew significant opposition from Blue Cross/Blue Shield plans and the National Association of Insurance Commissioners.

Blue Cross, the insurer of last resort for many States, fears that association health plans will undermine State programs to keep insurance affordable. Joined by the Health Insurance Association of America, they wrote, ''Association health plans would undermine the most volatile segments of the insurance market, the individual and small group markets. The combinations of these with healthmarts could lead to massive market segmentation and regulatory confusion.''

A constituent of mine and an insurance industry professional wrote to me to express his concerns about association health plans. He wondered why these plans ''can sell whatever level of benefits they want to provide and can limit coverage for any type of benefit the plan might want to cover.''

Now, some may say that these concerns reflect the self-interest of the industry. Before buying into that argument, consider an editorial by The Washington Post a year ago. In criticizing association health plans, and I would say, by extension, healthmarts, the Post pointed out that, ''if you free the MEWAs, multiple employer welfare associations, you create a further split in the insurance market which likely will end up helping mainly healthy people at the expense of the sick.''

Some may say that The Washington Post is a relentlessly liberal paper and that it cannot be considered an objective source. Then consider what the American Academy of Actuaries had to say about association health plans. In a letter to Congress in June, 1997, they wrote, ''While the intent of the bill is to promote association health plans as a mechanism for improving small employers' access to affordable health care, it may only succeed in doing so for employees with certain favorable risk characteristics. Furthermore, this bill contains features which may actually lead to higher insurance costs.''

The Academy went on to explain how these plans could undermine State insurance regulation. ''The resulting segmentation of the small employer group market into higher and lower cost groups would be exactly the type of segmentation that many State reforms have been designed to avoid. In this way, exempting them from State mandates would defeat the public policy purposes intended by State legislatures.''

The Academy also pointed out that these plans ''weaken the minimum solvency standards for small plans relative to the insured marketplace, which may increase the chance for bankruptcy of a health plan.''

Still not convinced? Well, how about a letter jointly signed by the National Governors Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners. In a letter to Congress, these groups argued that association health plans, and I might add healthmarts, ''substitute critical State oversight with inadequate Federal standards to protect consumers and to prevent health plan fraud and abuse.''

Think these are just the concerns of Washington insiders? Legislators in my own State took time to write and express their concerns about association health plans. A letter signed by six members of the Iowa House of Representatives urged rejection of association health plans. They wrote, ''Under the guise of allowing employers to join large purchasing groups to lower health care costs, these proposals would result in large premium increases for small employers and individuals by unraveling State insurance reforms and fragmenting the market.''

Mr. Speaker, attempting to attach association health plan legislation or healthmart legislation to patient protection legislation poses two very real dangers. First, association health plans undermine the individual insurance market and can leave consumers without meaningful protections from HMO abuses; and, second, I am very concerned that opposition to healthmarts and association health plans, much like that I have already cited today, will bog down patient protection legislation, leading it to suffer the same death that it did last year.

Mr. Speaker, on behalf of patients like Jimmy Adams, who lost his hands and feet because an HMO would not let his parents take him to the nearest emergency room, I will fight efforts to derail managed care reform by adding these sorts of extraneous provisions; and I pledge to do whatever it takes to ensure that opponents of reform are not allowed to mingle these issues in order to prevent passage of meaningful patient protections.

Mr. Speaker, I look forward to working with all my colleagues to see that passage of real HMO reform is an accomplishment of the 106th Congress, something we all, on both sides of the aisle, can be proud of.

RECESS

The SPEAKER pro tempore (Mr. PEASE). Pursuant to clause 12 of rule I, the Chair declares the House in recess until approximately 6 p.m.