Mr. PALLONE. I thank the gentlewoman from Connecticut. This is just the beginning.

I heard one of our colleagues from Texas on the other side talk about the rule and the Committee on Rules and how this managed care debate is going to be formulated. Obviously, we will keep our eye on this to see how the procedure goes. But every indication I have today from the Republican leadership, not from the Republicans that support the Patients' Bill of Rights but from the leadership, is that they are going to try to muck this up and make patient protections impossible.

MANAGED CARE REFORM

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, we are about 1 week from having at least 1 day of debate here on the floor of the House of Representatives on managed care reform and, hopefully, we will pass the bipartisan consensus patient protection bill of 1999.

There has been a lot of talk about what is in this bill, so I want to go over some of the specifics. And then I want to focus a little bit about some of the miscommunication that has been put out about the bill in regards to its liability section, since I was largely responsible for writing the liability section in a previous bill.

First of all, the bipartisan consensus patient protection bill of 1999 deals with access to care. I think the opponents to this legislation want to focus on one issue, and that is the liability provisions. But there is a lot in this bill. This is a comprehensive bill that is important to the people of this country, and it is part of the reason why over 300 organizations, patient advocacy groups, consumer groups, provider groups, have endorsed this bill.

What are some of the provisions in the bill that make this an excellent bill? First of all, access to emergency services. Individuals should be assured that if they have an emergency, those services will be covered by their plan. The bipartisan consensus bill says that individuals must have access to emergency care without prior authorization in any situation that a prudent layperson would regard as an emergency.

What does this mean? Well, this means that if, for instance, an individual wakes up in the middle of the night and has crushing chest pain, is hot and sweaty, and that individual happens to remember an ad put on TV by the American Heart Association that these could be signs an individual could be suffering from a heart attack, that that individual can go to the nearest emergency room, pronto, to be treated. That is what a prudent layperson would define as a potentially impending fatal heart attack.

Now, the problem that we have had is that a lot of HMOs will say that if the tests show that the patient is actually not having a heart attack, even though the symptoms indicated that they were, if the tests after the fact show that the electrocardiogram was normal, that maybe the individual was suffering severe inflammation of the esophagus or the stomach, they say, well, see, the patient was not really having a heart attack so they did not really need to go.

The problem with that is that when that kind of attitude gets around, people then start worrying that they are going to be stuck with a big bill and they may then delay getting the needed care that they need in an expeditious fashion. The next time it happens it may really be a heart attack, the individual may delay taking action, and then they may not make it to the emergency room.

That is the type of thing that we are looking at fixing in this bill. We did this for Medicare, by the way. This should be a noncontentious issue. We have already passed that provision for Medicare. Why can we not apply it to everyone in this country who buys insurance? Especially those who take up HMO insurance.

How about the provisions for specialty care? Patients with special conditions should have access to providers who have the expertise to take care of them. The bipartisan consensus bill allows for referrals for people to go outside of the plan's network for specialty care at no extra cost for the enrollee, if there is no appropriate provider in that health plan. This is really important to a lot of consumer groups, a lot of patients with certain types of chronic care that need a specialist. A person with rheumatoid arthritis, for instance.

Chronic care referrals for individuals who are seriously ill or require continued care by a specialist. A plan should have a process for selecting a specialist who can be the regular doctor for that patient, so that every time a patient has to go and see their cancer doctor they do not have to get a referral from the health plan.

How about women's protections? The bipartisan consensus bill provides for direct access to obstetricians and gynecologists for services.

Children's protections. The bipartisan bill ensures that the special needs of children are met, including access to pediatric specialists. Children are not just little adults. Before I came to Congress, I was a reconstructive surgeon. I took care of a lot of children with birth defects. They have special needs. If a child has cancer, that child ought to have access to a pediatric oncologist.

Continuity of care. Patients should be protected against disruptions in care because of a change in the plan or a change in the provider's network status. Let us say a woman is a couple months from delivering. She has been followed by her obstetrician for two-thirds of her pregnancy. All of a sudden the plan says, well, we are changing the plan. This guy or this woman is no longer in the plan. That is a significant disruption in care.

How about somebody who is dying and they have been followed or taken care of by a certain physician? There are certain benefits to continuity of care in terms of quality of care, and we ought to make sure that people who are right in the midst of complicated treatments do not have their care disrupted by a plan arbitrarily changing their physicians.

Clinical trials. This is part of the reason why, for instance, the American Cancer Society has endorsed the bipartisan consensus managed care patient protection bill. Access to clinical trials can be crucial for treatment of an illness, especially if it is the only known treatment available. Plans under this bill must have a process for allowing certain enrollees to participate in approved clinical trials, and the plan must pay for the routine patient costs associated with those trials. That is in our bill.

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Drug formularies. Prescription medications are not one size fits all. For plans that use a formulary, beneficiaries should be able to access medications that are not on that formulary when the prescribing physician dictates.

Choice of plan. Choice is one of the key elements in consumer satisfaction with the health system. The bipartisan consensus bill would allow individuals to elect a point of service option when their health insurance plan did not offer access to non-network providers. Any additional costs would be borne by the patient. This is a fair compromise.

People should be informed about decisions about their health plan options, and they can only know what their plan is doing if their plan provides them with sufficient information. This bill requires managed-care plans to provide important information so that consumers can understand their plan's policies, their plan's procedures, their plan's benefits and requirements.

I mean, a lot of opponents to this legislation say, oh, just let the free market work. Well, the free market is not really working, because most people do not have a choice for their health plans. Most employers will select one plan, most frequently on the basis of cost; and then they will say to the employee, take it or leave it. So it is not like the employee is getting that choice.

People who are denied care ought to have a reasonable utilization review process. When a plan is reviewing the medical decisions of its practitioners, it should do so in a fair and rational manner. This bill lays out basic criteria for a good utilization review program with physician participation in the development of the review criteria, the administration by appropriately

qualified professionals, timely decisions within 14 days for ordinary care, up to 28 days if the plan requests additional information within the first 5 days or 72 hours if they need an urgent decision.

They should have the ability to appeal those decisions, and they should be able to appeal in a fair process within the plan. And they ought to have an external appeal so that if at the end of their utilization review or their internal appeal within their plan and the plan is still saying, no, we are not going to give you this care and everything you have read about it and your own physician is telling you this is prevailing standards of care and you can be harmed without it, then an individual ought to have access to an external, independent body with the capability and authority to resolve disputes for cases involving medical judgment by the plan.

The plan should pay the costs of that process and any decision should be binding on the plan. And that is what is in our bill. If a plan refuses to comply with the external reviewer's determination, the patient should be able to go to Federal court to enforce that decision. And there could be a penalty. And that is in our bill.

I am going to talk about liability, though, if there is an injury. There are certain things in this bill that to me, as a physician, are absolutely essential for good health care. Consumers should have the right to know all of their treatment options. A few years ago I gathered together about 50 examples of contractual language from HMOs. Some plans try to limit the amount of information that you can receive from your doctor.

Let me give my colleagues an example of how this can work. Let us say a woman would come to me with a lump in her breast. She would give me her history. I would examine her breast. Under those types of gag rules and those contract clauses that some HMOs have put out, before I could tell this woman what her three treatment options were, one of which might be more expensive than the other, I would be obligated to first phone the health plan and say, Mrs. So-and-so has this problem. Can I tell her about all three treatment options?

I mean, can you think of anything that would be worse in terms of a patient wondering whether they are being leveled with by their doctor? I mean, I am not saying that a plan cannot write a specific exclusion of coverage into their plan.

Let us say that a plan says we are not going to cover liver transplants. Well, that is a decision that that employer and that health plan is making. I would hope that an employee would have a choice to choose another plan.

Let us say that a patient comes in to see me as a physician and their treatment option is a liver transplant; that is the only thing that might save their life. Whether their plan pays for it or not, that patient has a right to know that that treatment is available that could save their life.

Now, the plan may not like the patient to know that because a patient might be unhappy about that. But the patient has the right to know that. That is in our bill.

There should be prompt payment of claims. Health plans should operate efficiently. There should be paperwork simplification. And finally, let us get back to the issue of responsibility.

As a Republican, I have voted many times for legislation that would make people and entities responsible for their actions. I know most of my Republican colleagues on this side of the aisle feel the same way. If a criminal commits a murder, that person should be responsible for his actions. We have passed several pieces of legislation that involve the death penalty for that type of behavior. That is responsibility.

We passed the welfare reform bill a few years ago. We said, look, if you are able-bodied and you can work, we will give you some help, some education. But ultimately it is your responsibility to go out and support your family. That is responsibility.

We have a situation here where, because of a law that was passed by Congress 25 years ago, employer health plans are not responsible for their medical decisions that can result in injury. That sort of seems unbelievable, does it not? I mean, the only health plans in the country that have that kind of exemption from liability, from responsibility for injury that they can incur on a patient because of their decisions are employer group health plans.

The Members of Congress receive their insurance through what is called the Federal Employee Health Benefit Plan. Do you know what? If our plans are not providing care, then a Member of Congress could sue that health plan if that health plan resulted in injury to a Congressman's family. Because it is not an ERISA plan, it is not one of those employer plans. Other Government employees have the same right.

Church groups, for instance, that provide health benefits for their employees, those health plans are not free of any responsibility. When an insurance company sells a health policy to an individual and is under State insurance regulation, they are not free of responsibility for injuries that can result from their medical decisions. It is only these plans that, by a 25-year-old Federal law, gave an exemption for liability that they can cause injury to a patient, they can arbitrarily define what ''medical necessity'' is, and you have no recourse other than to recover the cost of the treatment that was not provided, which, by the time you could get through that procedure might mean that you are dead.

Let me give my colleagues an example of what I am talking about. This is a little baby that I have treated before. I treated him for cleft lip palate, a birth defect. The standard treatment for this is surgical correction, both of the lip and of the palate. There is a functional reason for that. Without that surgical correction, if you eat, food comes out of your nose and you cannot speak correctly. And speech is an absolutely essential part of our culture.

So all insurance companies that I know of in the past, traditional insurance companies, do not consider correction of this birth defect, do not consider correction of this birth defect, a cosmetic procedure. This is a reconstructive procedure.

But under this Federal law that I am talking about, the ERISA law, the Employee Retirement Income Security Act, from about 5 years ago, an employer plan can define ''medical necessity'' as ''the cheapest, least expensive care,'' and they could say, no, we are not going to authorize a surgical repair for this birth defect. We are just going to give this little kid a piece of plastic to shove up into the roof of his mouth, something like an upper denture, and maybe that will help keep the food from coming out of his nose.

And do my colleagues know what? They would have no legal recourse to challenge that HMO. That is Federal law that allows them to do that. You could say that medical decision you are making, that medical judgment of ''medical necessity'' is wrong; it does not fit any of the proscribed norms for treatment. And it results in injury to this child. Because if he does not get his palate corrected, really, by about the age of one, he may have a speech impediment the rest of his life. And do my colleagues know what? They would have no legal recourse under that Federal law. That is wrong. That is not justice.

Let me give my colleagues another case. We have here a little boy who is tugging on his sister's sleeve. This picture was taken shortly before he was 6 months old. When he was 6 months old, one night about 3 in the morning he had a temperature of about 105 and he was pretty sick. And this beautiful little boy, looking so sick, caused his mother to phone the HMO and say, my little boy Jimmy is sick. He has a temperature of 104, 105. I need to take him to an emergency room.

She was on a 1–800 number, somebody thousands of miles away, who said, well, you know, when we look at your State, this was in Georgia, I can authorize you to go to this emergency room. And the mother said, well, that is fine. But where is it? Well, I do not know. Look at a map.

It turns out that the authorized emergency room was 70-some miles away, clear on the other side of Atlanta, Georgia. The mother knew that if she went and took him to another emergency room that is not authorized, they would be stuck with a great big hospital bill. So she wraps up little Jimmy. Ma and Dad get in the car and they start their trip, 3 in the morning. And about halfway there, they pass

three hospitals that have emergency rooms and great pediatric care facilities. But they do not stop because they have not received authorization from that HMO reviewer who made a medical judgment over the phone. The medical judgment was Jimmy is okay to travel 70 miles on a prolonged ride.

Before they get to the authorized hospital, little Jimmy has a cardiac arrest. His heart stops. He is not breathing. Picture Mom trying to resuscitate him. Dad is driving like crazy. They finally pull into the emergency room entrance. Mom leaps out of the car with little Jimmy, screaming, Save my baby. Save my baby.

A nurse runs out, gives him mouth-to-mouth resuscitation. They start the IVs. They pound his chest. They resuscitate him, and they get him back and they manage to safe his life.

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Except they cannot quite save all of little Jimmy. Because he had that cardiac arrest, he ends up with gangrene of both hands and both feet, and both hands and both feet have to be amputated. This is a consequence of the medical judgment, the medical decision that that HMO reviewer at the end of a thousand-mile, 1–800 number made.

A judge reviewed this case. Of course under ERISA, the plan is liable for nothing other than the cost of the amputations. But a judge reviewed the case, and he came to the conclusion that the margin of safety for this HMO was, as he put it, ''razor thin.'' I would add to that, as razor thin as the scalpel that had to amputate little Jimmy's hands and feet.

The opponents to this legislation who want to maintain this type of legal immunity, they refer to cases like James Adams as ''anecdotes.'' They say, ''Oh, don't legislate on the basis of anecdotes.'' I look at this little boy, and I think, is this an anecdote? I mean, this little boy is never going to play basketball. I tell the Speaker of the House, this little boy will never be able to get on the wrestling mat. This little boy when he grows up and he marries the woman that he loves will never be able to caress her face with his hand. This anecdote that the HMOs say we should not legislate on, if he had a finger and you pricked it, he would bleed.

This is not just that a health plan can make that type of medical judgment and not be responsible for the injury that results. Plans should be more careful than that. The liability part is the enforcement mechanism to ensure that plans are more careful.

Now, look. The point of showing little Jimmy Adams is not necessarily to say that we need a lawsuit. My point is this: We need a mechanism to prevent this type of tragedy from happening. And we need the encouragement to the HMOs to follow that process. And the process would work like this: If somebody has an illness and they have a denial of care by their HMO and they go through that internal appeals process and they are still not satisfied, they can take that to an independent panel which would make a determination on medical necessity. We know from where this type of process has been set up that more than half of the time, the independent appeals boards agree with the health plan on the denial of care. But 50 percent of the time they agree with the patient. And if they agree with the patient and they tell them, the health plan, you should provide this treatment and the health plan does that, then under our bipartisan, common sense, compromise bill, that health plan is free of any punitive damages liability because they are simply following the independent external appeals recommendation. That is something that would be available for all health plans, whether they are ERISA plans or plans that are selling to individuals. That is a fair compromise on this issue. But if they do not follow those recommendations and you end up with an injury like this, then the plan is going to be liable under that State's laws, just as if they had sold that policy to the Adams family on their own, as individuals, rather than through their employer.

I hear an awful lot from the opponents to this legislation that you are just going to make the employers liable. Well, I would refer colleagues from both sides of the aisle to the actual bill, to page 97. We say that health plans are not exempted from liability. Health plans are not. But as long as the employer has not entered into that decision-making by that HMO, then the employer is not liable.

Madam Speaker, I have here a legal brief from the law firm of Gardner, Carton & Douglas which discusses this liability provision in some detail for the Norwood-Dingell bill.

Let me just summarize what this says on the liability provisions.

This says, ''Managed care industry miscommunications on this liability provision do not present an accurate analysis of the plan sponsor protections in the bill. The HMO industry claims the bill would subject plan sponsors, i.e., the employers, to a flood of lawsuits in State courts over all benefits decisions under their group health plans, and suggest that plan sponsors would be forced to abandon their plans. All of this is incorrect, for the following reasons.''

This is just a summary.

First, almost all lawsuits would not be against plan sponsors. Under current ERISA preemption law, suits seeking State law remedies for injury or wrongful death of group health plan participants are already allowed in numerous jurisdictions. Those cases show that these suits are normally brought against the HMO, not against the employer. The employers are generally not involved in ''treatment'' decisions that lead to a plan participant's, to the employee's, injury or death. ''Ordinary'' benefit decisions, such as whether to reimburse particular medical expenses, are not affected by our bill.

Second, the plan sponsor exposure would be limited. If a plan sponsor, i.e., the employer, exercises discretion in making a benefit claim decision and that decision results in injury or wrongful death, section 302(a) in our bill makes an exception to ERISA to allow a State claim. However, to recover, a plaintiff, the patient, or his family must first prove that the sponsor exercised discretion which resulted in the injury or death and then must prove all elements of a State law cause of action based on the sponsor's conduct in making the decision on that particular claim. The plaintiff must have a viable State law cause of action because our bill only creates an exception to ERISA preemption. It does not create a new cause of action.

Third. The statute's ''plain meaning'' limits plan sponsor liability. The provisions in our bill that protect plan sponsors would be interpreted under the Supreme Court's well-established ''plain meaning'' analysis. Such an analysis supports the bill's clear intention to continue to preempt any State law liability suits against employers that do not involve an exercise of discretion by them in making a decision that results in injury or death. Other types of ''discretionary'' plan sponsor action would not be affected and would not be subject to State law liability claims.

Finally, the private sector health care would not be destroyed. The limited legal exposure of employers under this bill will not cause them to abandon group health plans. The experience of retirement plans and ''non-ERISA'' plans, group health plans, support that conclusion. Plan sponsors would not need to abandon all control over group health plans to remain protected.

Madam Speaker, I include the foregoing document in its entirety for the RECORD:

[Memorandum]

From: Gardner, Carton & Douglas.
Date: September 27, 1999.
Subject: Liability of Plan Sponsors Under the Norwood-Dingell Bill (H.R. 2723).

You have asked us to analyze whether Section 302(a) of H.R. 2723, the ''Bipartisan Consensus Managed Care Improvement Act of 1999'' (the ''Bill'') could subject employers or others (such as labor organizations) who sponsor group health plans (''plan sponsors'') to potential liability under State law, for injuries or deaths resulting from coverage decisions under group health plans that they sponsor. As part of our analysis, you asked us to consider letters that have been prepared by some law firms for lobbying groups that are opposed to the Bill (the ''managed Care Letters'').

The Managed Care Letters do not focus on the central purpose of Section 302(a) of the Bill. That purpose is to fill an unintended gap under the Employee Retirement Income Security Act of 1974 (''ERISA''), by creating accountability for managed care organizations (''MCOs'') and others who make treatment decisions or provide services for participants in group health plans subject to ERISA. The gap results from judicial interpretations of ERISA which prevent the application of State law remedies that otherwise would redress an injury or death caused by

improper administration of a group health plan. Case law rules which attempt to define the limits of ERISA preemption in these circumstances are complex and differ from jurisdiction to jurisdiction. The Managed Care Letters shift attention from addressing this problem by characterizing Section 302(a) as an ''employer liability'' provision. Based on our analysis of Section 302(a), such a characterization is incorrect.

EXEUCTIVE SUMMARY

Protection for plan sponsors. The protection for plan sponsors included as part of Section 302(a) provides a meaningful and workable limitation on the potential State law liabilities otherwise allowed by the Bill.

Effect on ERISA preemption. Section 302(a) creates a limited exception to ERISA's general ''preemption'' of State laws that relate to employee benefit plans. The exception only applies to State law causes of action against any person based on personal injury or wrongful death resulting from providing or arranging for insurance, administrative services or medical services by such person to or for a group health plan. It does not disturb ERISA preemption of State law actions against a plan sponsor, except for actions based on the sponsor's exercise of discretion on a participant's claim for plan benefits resulted in personal injury or wrongful death of a participant. Other discretion by plan sponsors under a group health plan is not affected by Section 302(a).

The Bill's limited exception to ERISA preemption is not an ''employer liability'' provision. The Managed Care Letters do not present an accurate analysis of the plan sponsor protections in the Bill. They claim the Bill would subject plan sponsors to a flood of lawsuits in State courts over all benefits decisions under their group health plans, and suggest that plan sponsors would be forced to abandon their plans. All of this is incorrect, for the following reasons:

1. Most lawsuits would not be against plan sponsors. Under current ERISA preemption law, suits seeking State law remedies for injury or wrongful death of group health plan participants are already allowed in numerous jurisdictions. Those cases show that these suits are normally brought against MCOs—not against plan sponsors. Plan sponsors are generally not involved in ''treatment'' decisions that lead to a plan participant's injury or death. ''Ordinary'' benefit decisions (such as whether to reimburse particular medical expenses) are not affected by the Bill.

2. Plan sponsor exposure would be limited. If a plan sponsor exercises discretion in making a benefit claim decision under its group health plan, and that decision results in injury or wrongful death, Section 302(a) makes an exception to ERISA preemption to allow a State law claim against the sponsor. To recover, though, a plaintiff must first prove that the sponsor exercised discretion which resulted in the injury or death, then must prove all elements of a State law cause of action, based on the sponsor's conduct in making the decision on that particular claim for benefits. The plaintiff must have a viable State law cause of actions because Section 302(a) only creates an exception to ERISA preemption, and does not create a separate cause of action.

3. The statute's ''plain meaning'' limits plan sponsor liability. The provisions in Section 302(a) that protect plan sponsors would be interpreted under the Supreme Court's well-established ''plain meaning'' analysis. Such an analysis supports the Bill's clear intention to continue to preempt any State law liability suits against plan sponsors that do not involve an exercise of discretion by them in making a benefit claim decision resulting in injury or death. Other types of ''discretionary'' plan sponsor action would not be affected and would not be subject to State law liability claims. Interpretations of Section 302(a) which characterize it as a broad ''employer liability'' provision require one to ignore critical elements of Section 302(a), in violation of ''plain meaning'' analysis.

4. Private-sector health care would not be destroyed. The limited legal exposure of plan sponsors under Section 302(a) will not cause them to abandon group health plans. The experience of retirement plans and ''non-ERISA'' group health plans supports this conclusion. Plan sponsors would not need to abandon all control over a group health plan to remain protected. Having MCOs or other third parties make all claims decisions (as is often done), and then monitoring the third party preserves the sponsors' control. Or, sponsors could make the claims decisions and insure their exposure.

DISCUSSION

1. BACKGROUND

Relevant ERISA provisions. Section 502(a)(1)(B) of ERISA gives participants in an employee benefit plan subject to ERISA (including a group health plan) the right to sue: (i) to recover benefits due to them, (ii) to enforce their rights under the terms of the plan, or (iii) to clarify their rights to future benefits. Section 503 of ERISA and the regulations under that Section require every employee benefit plan to have procedures for notifying plan participants of denials of benefits and for appeals from such denials. Section 514(a) of ERISA states that the provisions of ERISA will supersede (''preempt'') any and all State laws which ''relate to'' employee benefit plans which are covered by ERISA.

Under these ERISA provisions, the Supreme Court and other federal courts have developed the following rules:

With limited exceptions, a participant must ''exhaust'' the ERISA claims appeal procedures under Section 503 before bringing a suit under Section 502(a)(1)(B). McGraw v. Prudential Insurance Co., 137 F.3d 1253, 1263–64 (10th Cir. 1998); Kennedy v. Empire Blue Cross and Blue Shield, 989 F.2d 588, 594–95 (2d Cir. 1993).

The ERISA causes of action are a participant's exclusive remedy to seek benefits or contest the administration of an employee benefit plan which is covered by ERISA. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 47–57 (1987).

State causes of action which seek to mandate benefits structures or administration of plans covered by ERISA are preempted, as are those which seek alternatives to ERISA's enforcement mechanisms. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 657–58 (1995).

Under the ERISA causes of action, a participant or beneficiary can recover benefits to which he or she is entitled and certain other equitable relief. Other compensatory, non-economic or punitive damages are not available. Mertens v. Hewitt Associates, 508 U.S. 248, 255–62 (1993).

Managed care and ERISA. In the traditional ''fee-for-service'' group health plan that was prevalent when ERISA was enacted in 1974, a lawsuit based on personal injury or wrongful death arising from treatment under the plan did not implicate ERISA. The participant received the care prescribed by his or her doctor, with payment made or reimbursed by an insurer. If there was a bad medical result, the participant could sue the medical care provider.

Managed care arrangements, which became prevalent only after ERISA's enactment, place an intermediary between the group health plan participant and the medical care that is provided. MCOs, through their protocols and ''utilization review'' procedures, make decisions affecting every aspect of the patient's treatment, including decisions on medical procedures, facilities utilized, access to specialists, length of stay, and drug prescriptions. The consequence of an improper or negligent decision on any of these matters can be injury or death to the patient.

Today, an employer that establishes a group health plan often arranges for an MCO to provide the benefits to plan participants or beneficiaries. The employer may pay the MCO on a capitated basis or it can ''self-insure'' by paying the cost of treatment provided by the MCO.

ERISA preemption and MCO accountability. The combination of ERISA preemption and the use of MCOs by group health plans to provide benefits has produced a startling and unintended result. The MCO used by a group health plan may make a highly negligent treatment decision, and a participant may be injured or die as a result. If the MCO's actions are treated as acts of administration of an ERISA-covered plan, and therefore qualify for protection under ERISA preemption, the MCO is not accountable at law for the injury or death which results from its actions.

This is because the State law remedies are preempted by ERISA, and the only remedies under ERISA are the plan benefits to which the participant is entitled. The ERISA remedy is usually meaningless after the injury or death has occurred. Thus, an ERISA group health plan participant can suffer a ''wrong without a remedy.'' See Corcoran v. United HealthCare, 965 F.2d 1321 (5th Cir. 1992); Kuhl v. Lincoln National Life, 999 F.2d 298 (8th Cir. 1993); Spain v. Aetna Life Insurance Co., 11 F.3d 129 (9th Cir. 1993).

This result can only occur if the patient is covered by a plan that is subject to ERISA. Group health plans maintained by federal, state and local governments, or by church organizations, are not subject to ERISA—and aggrieved participants in those plans can sue MCOs in state courts. So can individuals covered by Medicare, Medicaid or by insurance coverage that they purchase themselves. Thus, the interplay of ERISA preemption provisions and managed care practices has created a situation where participants in ERISA plans are the only Americans with health care coverage who cannot go to court to hold MCOs accountable for their negligent or wrongful actions.

Some federal courts have recognized this unintended and illogical situation, and have tried to distinguish MCO activities that involve administration of ERISA-covered plans for MCO activities that inolve medical decision-making and the practice of medicine. See, e.g., Dukes v. U.S. HealthCare Inc., 57 F.3d 350 (3rd Cir. 1995). these decisions have allowed injured patients or survivors of decreased patients to bring state court actions agaisnt MCOs in some jurisdictions, in some circumstances. However, courts taking this approach are forced to engage in a difficult hair-splitting analysis of whether the claim at issue involves the ''quantity'' of benefits a patient received or the ''quality'' of those benefits—with preemption in the ''quantity'' case, and no preemption in the ''quality'' cases. Recent cases show how problematic this analysis is, with different results occurring with similar facts. Compare, for example, the decision in Moscovitch V. Danbury Hospital, 25 F. Supp. 2d 74 (D. Conn. 1988), with the decision in Huss v. Green Spring Health Services, Inc., 18 F. Supp. 2d 400 (D. Del. 1998). In both cases, an MCO decision was alleged to have led to the suicide of a family's son. In Moscovitch, the State law

claims were permitted, but in Huss they were held to be preempted by ERISA.

MCO accountability to participants in ERISA-covered group health plans should not depend on such hair-splitting. Nothing in ERISA or its legislative history suggests that ERISA-which was passed to protect plan participants—was intended to put plan participants in a worse position than other Americans with health care coverage.

Section 302(a) of the Bill. Section 302(a) of the Bill addresses this problem by carefully supplementing the ERISA preemption rules, with a new ERISA Section 514(e). The new provision first provides, in Section 514(e)(1)(A), that ERISA will not preempt an action under State law to: recover damages resulting from personal injury or for wrongful death against any person—(i) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan * * * or (ii) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

Next is Section 514(e)(2)(A), a special rules expressly intended to protect plan sponsors. It fully restores ERISA preemption with respect to: any cause of action against an employer or plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting with the scope of employment).

Finally, Section 514(e)(2)(B) states that the Section 514(e)(2)(A) protection for plan sponsors will not bar State law causes of action otherwise allowed by Section 502(e)(1), if: (i) such action is based on *the employer's or other plan sponsor's* (or employee's) *exercise of discretionary authority to make a decision on a claim for benefits covered under the plan* * * * and (ii) the exercise by such employer or other plan sponsor (or employee) of such authority *resulted in personal injury or wrongful death*. [Emphasis added.]

II. ANALYSIS

A. How likely are lawsuits against plan sponsors?

the structure of the proposed new ERISA Section 514(e), and the actual case law experience in jurisdictions which have allowed some suits against MCO's by participants in ERISA group health plans, both indicate that the ''flood'' of litigation against plan sponsors predicted in the Managed Care Letters is unlikely to occur.

Most group health plan benefit claims would be unaffected. New ERISA Section 514(e)(1) would permit state court suits against a person only where there is a personal injury or wrongful death. The vast majority of the ''benefit claims'' under group health plans do not involve personal injury or wrongful death, but instead involve matters such as: whether a person is eligible as a participant under the plan, attempts to secure pre-approval for a particular medical procedure or course of treatment; and claims for reimbursement of medical expenses already incurred by the participant or beneficiary.

These disputes are untouched by the Bill. They are still subject to the ERISA Section 503 claims and appeals procedures (including the alternative procedures provided by the Bill), and then (following exhaustion of the Section 503 procedures) could be pursued only in a suit under ERISA Section 502(a)(1)(B), where the plaintiff could only seek the limited remedies available under ERISA.

No cause of action available against plan sponsors in many cases. Putting aside the bulk of group health plan disputes, which stay within current ERISA procedures (including the alternative procedures provided by the Bill), we can turn to those which do involve allegations of personal injury or wrongful death. How likely is it that a plan sponsor will be sued in state court if such suits are permitted under new ERISA Section 514(e)(2)(B)?

Since 1994, a number of jurisdictions have allowed some state lawsuits based on personal injury or wrongful death of ERISA plan participants. Numerous suits like this have been brought, with some allowed to go forward in state court and others found to be preempted by ERISA. We have reviewed every reported opinion involving such a case.

As we analyzed the facts of these cases, as set out in the reported opinions, we found that the plan sponsor was almost never shown or described as a defendant. Specifically, in only two of the 75 cases we reviewed was there anything to indicate that the plan sponsor was sued, even though the plan sponsor might have selected the MCO and/or retained final discretion on claims appeals. Every other conceivable party seems to have been sued in these cases, including doctors, nurses, hospitals, MCOs and equipment manufactures, but not plan sponsors.

Why aren't plan sponsors (employees) typically sued? The reason why plan sponsors are not sued in these cases is probably because the personal injury or wrongful death occurs as a result of MCO actions in which the plan sponsor is not involved. The plan sponsor is not a part of the faulty diagnosis, the premature discharge, the use of the inappropriate drug or procedure, the refusal to admit, or the delay in surgery. It is these events which cause the alleged injuries and deaths. These are the well-publicized cases which have led congress to consider managed care reform. However, these are not plan sponsor decisions and are not likely to support a cause of action against the plan sponsor under the Bill's limited exception to ERISA preemption.

More specifically, the state law causes of action likely to be pleaded in situations like this have specific elements, all of which have to be established against a defendant. Many of the cases brought against MCOs are medical malpractice cases which would be inapplicable to plan sponsors (except, perhaps, where the group health plan actually operated a hospital or clinic). Negligence actions require a duty of care, as established by law, and a breach of that duty which is a proximate cause of the injury. Wrongful death statutes typically require a wrongful act which would have been actionable by the decedent, and which caused his or her death. The MCO actions attacked in the cases we reviewed could support such claims against an MCO, but not a plan sponsor. That is why plan sponsors were not defendants in the cases we reviewed, and why it seems they are not likely to be sued in similar situations if the Bill is enacted.

''Emotional distress'' claims. A related point which should be addressed is whether the Bill would permit a suit against a plan sponsor based on ''emotional distress.'' One of the Managed Care Letters suggests that a participant could seek mental health benefits, be denied, then sue in state court for ''denied benefits, emotional distress and lost job opportunities.''

Such a suit would not survive a motion to dismiss. While state courts may permit recovery for ''emotional distress'' or ''mental anguish'' without an accompanying physical injury, the proposed Section 514(e)(1)(A) requires a suit ''for personal injury or for wrongful death'' before there is any preemption of ERISA. ''Personal injury'' means ''physical injury'' (including physical injury arising out of treatment or non-treatment of mental disease). Therefore, absent physical injury, ''emotional distress'' is not enough to trigger the exception to preemption, and the state law claims are absolutely barred by Pilot Life.

The preceding analysis actually shows how effectively proposed Section 514(e) would work. First, the requirements for the exception to ERISA preemption (including the plan sponsor exercising discretion which results in personal injury or wrongful death) must be met; then all the elements of an applicable State law cause of action must be satisfied.

Where State law suit against plan sponsor would not be preempted. Without question, a plan sponsor could engage in conduct where it could be sued under the proposed new Section 502(e). For example, a participant could seek a cutting-edge cancer treatment, be denied and appeal to the plan sponsor's ''Benefits Committee.'' If that Committee denied the appeal and the participant died, a wrongful death action could be brought. But the plaintiff would have to prove the state law claim—showing, for example, that the Committee decision was in violation of a legal ''duty of care'' owed to the participant, and that it was the ''proximate cause'' of the participant's death. Cases like this occur, but they are not everyday matters, even in a large group health plan. The plan sponsor can insure against such liability, and can establish claims appeal procedures to build a record which can withstand scrutiny. In the alternative, it can transfer the appeals function to a third party with medical expertise, and monitor that entity's performance.

Once the scope and operation of the Bill's exception to ERISA preemption is examined, and once the characteristics of current suits against MCOs are reviewed, concerns about a ''flood'' of lawsuits against plan sponsors under the Bill should greatly diminish.

B. How likely is an interpretation of the Bill allowing broad plan sponsor liability?

Arugments in the Managed Care Letters. Ignoring both the limited scope of the proposed changes to ERISA and the detailed plan sponsor protection, the Managed Care Letters predict dire consequences from the Bill. They argue that the plan sponsor protections will be illusory, and that the Bill would subject plan sponsors to potential State court litigation over every coverage decision under a group health plan. The Managed Care Letters go on to state that this broad liability for plan sponsors would put them in an untenable position and make group health plans unworkable. Several arguments are made in support of these assertions.

''Discretion''. The Managed Care Letters suggest that, because ''discretionary action'' can occur in many contexts under ERISA, virtually any plan sponsor action regarding a group health plan will involve an ''exercise of discretionary authority'' that would make the plan sponsor subject to State law actions.

Imputed actions. The next argument is that under general agency concepts, the actions of a decision-maker, such as an MCO third party would be ''imputed'' to the employer, and the employer would thereby be deemed to have made an ''exercise of discretionary authority to make a decision on a claim for benefits covered under the plan.''

Retained control. Similarly, it is argued that, in reality, a plan sponsor will always retain some control over the actions of the MCO, and therefore will always be deemed to have exercised discretionary authority to make a decision on a claim for benefits covered under the plan.

Each of these objections can be addressed by applying the ''plain meaning'' rule of statutory construction to the proposed new ERISA Section 514(e).

Plain meaning—overview. The new ERISA Section 514(e) contained in the Bill, if enacted, would be subject to a well-established

rule of statutory interpretation which focuses on the ''plain meaning.'' This rule would strongly support the Bill's clear intention to prevent State law liability for plan sponsors that do not directly exercise discretion in making a benefit claim decision under their group health plan. Other types of ''discretionary'' plan sponsor actions would be well outside of the scope of the plain meaning of proposed Section 514(e)(2)(B).

The Supreme Court has repeatedly confirmed that the starting point to determine the meaning of a federal statute is the plain language of the statute itself. See, e.g., Central Bank of Denver v. First Interstate Bank of Denver, 511 U.S. 164, 171 (1994). If a court finds that this statutory language is unambiguous, the inquiry should be complete. See, e.g., Ardestani v. Immigration and Naturalization Service, 502 U.S. 129, 135 (1991).

Most importantly, with regard to the overbroad, hypothetical interpretations of proposed Section 514(e) found in the Managed Care Letters, the Supreme Court has confirmed that ''assertions of ambiguity do not transform a clear statute into an ambiguous provision,'' and that courts must be skeptical of clever readings of a statute that are based on ''ingenuity.'' United States v. James, 478 U.S. 597, 604 (1986). The Supreme Court has similarly stated that a statute can be viewed as unambiguous ''without addressing every interpretative theory offered by a party.'' Salinas v. United States, 118 S. Ct. 469 (1997).

This ''plain meaning'' approach has been used by the Supreme Court in a number of recent cases reviewing disputes involving federal employment laws. See, e.g., Hughes Aircraft Company v. Jacobson, 199 S. Ct. 755 (1999) (dispute under ERISA); Sutton v. United Air Lines, 119 S. Ct. 2139 (1999) (dispute under the Americans with Disabilities Act); Murphy v. United Parcel Service, 119 S. Ct. 2133 (1999) (same).

Plain meaning—applied to ''discretion.'' The Bill contains clear, straightforward language that allows State law actions otherwise allowed by the Bill to apply to a plan sponsor only when it engages in a direct exercise of discretionary authority to make a decision ''on a claim for benefits covered under the plan.''

To begin, the structure of proposed Section 514(e) is straightforward. New Section 514(e)'s structure of (1) rule, (2) exception, and (3) exception-to-the-exception, is orderly and understandable.

The Managed Care Letters argue that, under ERISA Section 3(21)(A), many types of ''discretion'' can create a fiduciary status for a person administering an employee benefit plan. This is true, but it is irrelevant to the plan sponsor protection provided by the Bill. Under the bill's literal language, plan sponsor protection is not lost whenever there is some exercise of discretion by a plan sponsor. It is only lost when there is plan sponsor discretion on ''a decision on a claim for benefits covered under the plan.''

The Managed Care Letters argue that, even with respect to discretion on claims for benefits, the Bill will be construed to broadly allow suits against plan sponsors under State law, because the plan sponsor may be viewed as ''indirectly'' exercising this discretion, for instance, by appointing the MCO which actually exercises discretion. Such an interpretation would read the words of Section 514(e)(2)(B) right out of the statute. This is precisely what is prohibited by the ''plain meaning'' rule.

In addition, the Bill carves out, in new Section 514(e)(2)(C), several specific plan sponsor activities which will not, in any event, constitute an exercise of discretionary authority on a benefit claim. They are: (i) decisions to include or exclude any specific benefit from the plan; (ii) decisions to provide extra-contractual benefits outside of the plan; and (iii) decisions not to consider the provision of a benefit while an internal or external review of the claim is being conducted. These carve-outs further insulate plan sponsors from State law actions in ''close call'' situations.

Plain meaning—applied to ''imputed actions'' and ''retained control.'' It is unrealistic to argue, as the Managed Care Letters do, that under general ''agency law'' concepts, actions of a third party decision-maker, such as an MCO, would be ''imputed'' to the plan sponsor, who would then be deemed to have made an ''exercise of discretionary authority'' on a claim for benefits covered under the plan, through the appointment or under some notion of ''ultimate control'' of the group health plan.

There are two flaws in this argument. First, proposed ERISA in Section 514(e)(2)(A) clearly shields plan sponsors from the exception to ERISA preemption in Section 514(e)(1). If proposed Section 514(e)(2)(B)—which is set up as an exception to that shield—made plan sponsors subject to State law suits for the acts of others, plan sponsors would be in the same place as MCOs and others against whom State law suits would be allowed under Section 514(e)(1). This interpretation found in the Managed Care Letters would impermissibly read the exception right out of the statute and make the clear language of Section 514(e)(1)(A) meaningless. This is exactly what is prohibited by the ''plain meaning'' rule of statutory construction—as well as by common sense.

In addition, the Managed Care Letters cite no relevant legal authority to support this interpretation. We reviewed the list of cases which one Managed Care Letter cites as a ''solid common law basis'' for its argument. What these cases deal with is an MCO's liability for the acts of health care providers which it employs or supervises. They have nothing to do with the relationship between plan sponsor and a service provider to its group health plan.

Therefore, we think that use of an ''agency'' or similar argument to expand the scope of plan sponsor exposure would be fundamentally at odds with the structure and plain meaning of Section 302(a).

C. How likely is it that plan sponsors would terminate group health plans under the Bill?

A perennial argument. The perennial argument against changes to employee benefits laws is that the changes will cause plan sponsors to abandon their plans. (Opponents to ERISA predicted that it would destroy the entire private-sector retirement plan system. It did not.) With regard to the Bill, the experience of ''non-ERISA'' group health plans and of retirement plans subject to ERISA indicates that new ERISA Section 514(e) would not cause wholesale terminations of group health plans.

What experience shows. ''Church plans'' provide a good reference. Under ERISA Sections 4(b)(2) and 3(33), an employee benefit plan sponsored by a church organization is not subject to ERISA. Church organizations routinely sponsor group health plans, and many utilize MCOs. With ERISA preemption unavailable to them, these church-sponsors are always potential targets for the kind of suits the Managed Care Letters direly predict. Yet churches continue to sponsor group health plans.

Sponsors of retirement plans subject to ERISA can be subject to suits over the use or investment of plan assets, with huge potential liabilities for breaches of ERISA fiduciary duty. For example, a major bank was recently sued for over $100 million in alleged losses to participants in its ''401(k)'' retirement plan, based on the fee structure and other issues related to the plan's investment options. Franklin v. First Union Corp., Civil Action No. 3–99CV610, E.D. Virginia (September 7, 1999). To our knowledge, no one is suggesting that employers will now abandon their ''401(k)'' or other retirement plans in the face of such potential liabilities.

Maintaining plan sponsor control. Nor do plan sponsors need to ''abandon all control'' of the retirement plans to avoid fiduciary liability. The investment management of retirement plan assets is a good example. More and more, sponsors of retirement plans have put the management of plan assets in the hands of banks, insurance companies and other professional investment managers. Plan sponsors engage in careful manager searches, establish investment policies and review the performance of the investment managers and, where they deem it appropriate, change managers. The plan sponsor then does not make day-to-day investment decisions, but it certainly does not abandon control over this plan function.

In the same say, a group health plan sponsor can choose an MCO, and provide for it to have final authority over benefit claims. The plan sponsor monitors the MCO's performance, including its medical outcomes, and can change MCOs if it is dissatisfied with the care provided by the MCO. In such a situation, the plan sponsor would not have potential liability under proposed ERISA Section 514(e), but would certainly retain control over the operation of its group health plan.

Therefore, based on the experience of ''non-ERISA'' group health plans and ERISA retirement plans, it seems highly unlikely that the Bill's State law liability provisions would mean the end of employer-sponsored group health plans, or that employers would be forced to abandon control of those plans.

CONCLUSION

Our analysis shows that Section 302(a) of the Bill, if enacted, would not expose plan sponsors to State law liability in most situations. Only to the extent that a plan sponsor directly exercised discretion in making a benefit claim decision under its group health plan, and to the extent that an improper decision then resulted in injury or wrongful death, would there be an exception to ERISA preemption which allowed a State law claim to be brought. This potential liability is consistent with general principles of tort law, where parties are liable for the consequences of their negligent actions.

Most benefits decisions in which plan sponsors participate are outside the scope of proposed new ERISA Section 514(e). A personal injury or wrongful death is required before a state law claim is allowed. Thus, claims seeking prior approval of specific benefits, or seeking reimbursement of medical costs already incurred, or seeking to clarify a person's status as a plan participant would continue to be handled through the existing ERISA claim and appeal procedures.

Where there is personal injury or wrongful death, and a State law suit against an employer is permitted, there must be an applicable state law cause of action—nothing in Section 302(a) creates an independent cause of action. If there is a potential state law claim, it will still be preempted by ERISA unless the plaintiff can show (1) that the plan sponsor exercised discretionary authority over a claim for benefits in the case at issue, and (2) the exercise of discretion resulted in personal injury of wrongful death.

Our review of the cases where ERISA plan participants have filed suit for personal injury or wrongful death indicates that, most commonly, patients are injured or die in circumstances where the plan sponsor is not involved. It is not the plan sponsor's Benefits

Committee which sends the mother home from the hospital with her sick newborn child, or refuses to scheduled urgent surgery. Speculation that plan sponsors will ''somehow'' face broad State law liability is inconsistent with an analysis of relevant case law and the ''plain meaning'' of the proposed statue.

In sum, Section 302(a) of the Bill is a carefully-drafted provision which addresses what many perceive as an unfortunate and unintended gap in ERISA, without disturbing the ERISA preemption rules applicable to most State law claims against plan sponsors of group health plans.

What is the real life experience to bear that out? I refer my colleagues to the front page story in the Washington Post today. ''Patients' Rights Case Study: So Far, Benign. In Texas, Ability to Sue HMOs Has Prompted Little Litigation.''

Why is that? Because whereas they say that plans that make decisions, medical decisions that result in injury are going to legally be liable, they also set up that dispute resolution process that is in our bill, a dispute resolution so that you can fix a problem before you end up with the injury.

It says here in this article:

''The insurance industry and its business allies have spent millions of dollars warning legislators in Washington that it would be dangerous to give patients the right to sue health maintenance organizations, arguing that the courts would be deluged with baseless litigation.

''But since the Texas legislature made managed care plans liable for malpractice, there have only been five known lawsuits from among the 4 million Texans who belong to HMOs.

''And despite insurers' arguments that such a law would force them to practice an expensive brand of defensive medicine, there is no sign that medical costs are rising faster in Texas than anywhere else in the country.''

It talks a little bit in this article about how this bill became law in Texas. But then it goes on to say:

''The bill passed with overwhelming support from both Republicans and Democrats in Texas. Governor Bush, now a Republican presidential candidate, had opposed the idea of allowing HMOs to be sued. But this time, in a position that puts him at odds with GOP leaders in Congress, he let the law take effect.

''Two years later, a Bush spokesman said the governor believes the law has 'worked well,' primarily because of a grievance system included in the legislation that has ruled on about 600 cases and sided with patients about half the time. 'We have not seen an explosion of lawsuits,' said Governor Bush's spokesman Ray Sullivan. 'That's what the governor wanted.'''

Madam Speaker, because this is a comprehensive bill that includes so many good provisions to help patients get the kind of care that they need, it is not just a liability bill, it is a bill that because of these other provisions that will allow patients who are not getting a fair shake from their HMOs to have a process to get that fixed, we have 300 organizations who have endorsed the bipartisan consensus bill, H.R. 2723.

Madam Speaker, I include this list for the CONGRESSIONAL RECORD.

300 ORGANIZATIONS ENDORSING H.R. 2723

Adapted Physical Activity Council.
AIDS Action.
Allergy and Asthma Network—Mothers of Asthmatics, Inc.
Alliance for Children and Families.
Alliance for Rehabilitation Counseling.
American Academy of Allergy and Immunology.
American Academy of Child and Adolescent Psychiatry.
American Academy of Emergency Medicine.
American Academy of Facial Plastic and Reconstructive Surgery.
American Academy of Family Physicians.
American Academy of Neurology.
American Academy of Opthamology.
American Academy of Otolaryngology—Head and Neck Surgery.
American Academy of Pain Medicine.
American Academy of Pediatrics.
American Academy of Physical Medicine & Rehabilitation.
American Association for Hand Surgery.
American Association for Holistic Health.
American Association for Marriage and Family Therapy.
American Association for Mental Retardation.
American Association for Psychosocial Rehabilitation.
American Association for Respiratory Care.
American Association for the Study of Headache.
American Association for Clinical Endocrinologists.
American Association of Clinical Urologists.
American Association of Hip and Knee Surgeons.
American Association of Neurological Surgeons.
American Association of Nurse Anesthetists.
American Association of Oral and Maxillofacial Surgeons.
American Association of Orthopaedic Foot and Ankle Surgeons.
American Association of Orthopaedic Surgeons.
American Association of Pastoral Counselors.
American Association of People with Disabilities.
American Association of Private Practice Psychiatrists.
American Association of University Affiliated Programs for Persons with DD.
American Association of University Women.
American Association on Health and Disability.
American Bar Association, Commission on Mental & Physical Disability Law.
American Board of Examiners in Clinical Social Work.
American Cancer Society.
American Chiropractic Association.
American College of Allergy and Immunology.
American College of Cardiology.
American College of Emergency Physicians.
American College of Foot and Ankle Surgeons.
American College of Gastroenterology.
American College of Nuclear Physicians.
American College of Nurse-Midwives.
American College of Obstetricians and Gynecologists.
American College of Osteopathic Family Physicians.
American College of Osteopathic Surgeons.
American College of Physicians.
American College of Radiation Oncology.
American College of Radiology.
American College of Rheumatology.
American College of Surgeons.
American Council for the Blind.
American Counseling Association.
American Dental Association.
American Diabetes Association.
American EEG Society.
American Family Foundation.
American Federation of HomeCare Providers, Inc.
American Federation of State, County, and Municipal Employees.
American Federation of Teachers.
American Foundation for the Blind.
American Gastroenterological Association.
American Group Psychotherapy Association.
American Heart Association.
American Liver Foundation.
American Lung Association/American Thoracic Society.
American Medical Association.
American Medical Rehabilitation Providers Association.
American Medical Student Association.
American Medical Women's Association, Inc.
American Mental Health Counselors Association.
American Music Therapy Association.
American Network of Community Options And Resources.
American Nurses Association.
American Occupational Therapy Association.
American Optometric Association.
American Orthopaedic Society for Sports Medicine.
American Orthopsychiatric Association.
American Orthotic and Prosthetic Association.
American Osteopathic Academy of Orthopedics.
American Osteopathic Association.
American Osteopathic Surgeons.
American Pain Society.
American Physical Therapy Association.
American Podiatric Medical Association.
American Psychiatric Association.
American Psychiatric Nurses Association.
American Psychoanalytic Association.
American Psychological Association.
American Public Health Association.
American Society for Dermatologic Surgery.
American Society for Gastrointestinal Endoscopy.
American Society for Surgery of the Hand.
American Society for Therapeutic Radiology and Oncology.
American Society of Anesthesiology.
American Society of Bariatric Surgery.
American Society of Cataract and Refractive Surgery.
American Society of Clinical Oncology.
American Society of Dermatology.
American Society of Echocardiography.
American Society of Foot and Ankle Surgery.
American Society of General Surgeons.
American Society of Hand Therapists.
American Society of Hematology.
American Society of Internal Medicine.
American Society of Nephrology.
American Society of Nuclear Cardiology.
American Society of Pediatric Nephrology.
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society of Transplant Surgeons.
American Society of Transplantation.

American Speech-Language-Hearing Association.
American Therapeutic Recreation Association.
American Urological Association.
Americans for Better Care of the Dying.
Amputee Coalition of America.
Anxiety Disorders Association of America.
Arthritis Foundation.
Arthroscopy Association of North America.
Association for Ambulatory Behavioral Healthcare.
Association for Education and Rehabilitation Of the Blind and Visually Impaired.
Association for Persons in Supported Employment.
Association for the Advancement of Psychology.
Association for the Education of Community Rehabilitation Personnel.
Association of American Cancer Institutes.
Association of Education for Community Rehabilitation Programs.
Association of Freestanding Radiation Oncology Centers.
Association of Maternal and Child Health Programs.
Association of Subspecialty Professors.
Association of Tech Act Projects.
Association of Women's Health Obstetric and Neonatal Nurses.
Asthma & Allergy Foundation of America.
Austism Society of America.
Bazelon Center for Mental Health Law.
California Access to Specialty Care Coalition.
California Congress of Dermatological Societies.
Cancer Leadership Council.
Center for Patient Advocacy.
Center on Disability and Health.
Child Welfare League of America.
Children & Adults with Attention Deficit/Hyperactivity Disorder.
Children's Defense Fund.
Citizens United for Rehabilitation of Errants.
Clinical Social Work Federation.
Communication Workers of America.
Conference of Educational Administrators of Schools and Programs for the Deaf.
Congress of Neurological Surgeons.
Consortium of Developmental Disabilities Councils.
Consumer Action Network.
Consumer Federation of America.
Consumers Union.
Cooley's Anemia Foundation.
Corporation for the Advancement of Psychiatry.
Council for Exceptional Children.
Council for Learning Disabilities.
Crohn's and Colitis Foundation of America.
Diagenetics.
Digestive Disease National Coalition.
Disability Rights Education and Defense Fund.
Division for Early Childhood of the CEC.
Easter Seals.
Epilepsy Foundation of America.
Evangelical Lutheran Church in America.
Eye Bank Association of America.
Families USA.
Family Service America.
Family Voices.
Federated Ambulatory Surgery Association.
Federation of Behavioral, Psychological & Cognitive Sciences.
Federation of Families for Children's Mental Health.
Florida Breast Cancer Coalition.
Friends Committee on National Legislation.
Goodwill Industries International, Inc.
Gullain-Barre Syndrome Foundation.
Helen Keller National Center.
Higher Education Consortium for Special Education.
Human Rights Campaign.
Huntington's Disease Society of America.
Infectious Disease Society of America.
Inter/National Association of Business, Industry and Rehabilitation.
International Association of Jewish Vocational Services.
International Association of Psychosocial Rehabilitation Services.
International Dyslexia Association.
Joseph P. Kennedy, Jr. Foundation.
League of Women Voters.
Learning Disabilities Association.
Leukemia Society of America.
Linda Creed Breast Cancer Foundation.
Lupus Foundation of America, Inc.
Massachusetts Breast Cancer Coalition.
Medical College of Wisconsin.
Michigan State Medical Society.
Minnesota Breast Cancer Coalition.
National Alliance for the Mentally Ill
National Association for Medical Equipment Services.
National Association for Rural Mental Health.
National Association for State Directors of Developmental Disabilities Services.
National Association for the Advancement of Orthotics and Prosthetics.
National Association of Children's Hospitals.
National Association of Developmental Disabilities Councils.
National Association of Medical Directors of Respiratory Care.
National Association of Nurse Practitioners in Women's Health.
National Association of People with AIDS.
National Association of Physicians Who Care.
National Association of Private Schools for Exceptional Children.
National Association of Protection and Advocacy Systems.
National Association of Psychiatric Treatment Centers for Children.
National Association of Public Hospitals and Health Systems (Qualified Support).
National Association of Rehabilitation Research and Training Centers.
National Association of School Psychologists.
National Association of Social Workers.
National Association of State Directors of Special Education.
National Association of State Mental Health Program Directors.
National Association of the Deaf.
National Black Women's Health Project.
National Breast Cancer Coalition.
National Center for Learning Disabilities.
National Coalition on Deaf-Blindness.
National Committee to Preserve Social Security and Medicare.
National Community Pharmacists Association.
National Consortium of Phys. Ed. And Recreation For Individuals with Disabilities.
National Consumers League.
National Council for Community Behavioral Healthcare.
National Depressive and Manic-Depressive Association.
National Down Syndrome Society.
National Foundation for Ectodermal Dysplasias.
National Hemophilia Foundation.
National Medical Association.
National Mental Health Association.
National Multiple Sclerosis Society.
National Organization of Physicians Who Care.
National Organization of Social Security Claimants' Representatives.
National Organization on Disability.
National Parent Network on Disabilities.
National Partnership for Women & Families.
National Patient Advocate Foundation.
National Psoriasis Foundation.
National Rehabilitation Association.
National Rehabilitation Hospital.
National Therapeutic Recreation Society.
NETWORK: National Catholic Social Justice Lobby.
New York State Nurses Association.
NISH.
North American Brain Tumor Coalition.
North American Society of Pacing and Electrophysiology.
North American Spine Society.
Opticians Association of America.
Oregon Dermatology Society.
Orthopaedic Trauma Association.
Outpatient Ophthalmic Surgery Society.
Pain Care Coalition.
Paralysis Society of America.
Paralyzed Veterans of America.
Patient Advocates for Skin Disease Research.
Patients Who Care.
Pediatric Orthopaedic Society of North America.
Pediatrix Medical Group: Neonatology and Pediatric Intensive Care Specialist.
Physicians for Reproductive Choice and Health.
Physicians Who Care.
Pituitary Tumor Network.
Public Citizen (Liability Provisions Only).
Rehabilitation Engineering and Assistive Technology Society of N. America.
Renal Physicians Association.
Resolve: The National Infertility Clinic.
Scoliosis Research Society.
Self Help for Hard of Hearing People, Inc.
Service Employees International Union.
Sjogren's Syndrome Foundation Inc.
Society for Excellence in Eyecare.
Society for Vascular Surgery.
Society of Cardiovascular & Interventional Radiology.
Society of Critical Care Medicine.
Society of Gynecologic Oncologists.
Society of Nuclear Medicine.
Society of Thoracic Surgeons.
Spina Bifida Association of America.
St Louis Breast Cancer Coalition.
Taconic Resources for Independence, Inc.
The Alexandria Graham Bell Association for the Deaf, Inc.
The American Society of Dermatophathology.
The Arc of the United States.
The Council on Quality and Leadership in Supports for People with Disabilities (The Council).
The Endocrine Society.
The Paget Foundation for Paget's Disease of Bone and Related Disorders.
The Society for Cardiac Angiography and Interventions.
The TMJ Associations, Ltd.
Title II Community AIDS National Network.
United Auto Workers.
United Cerebral Palsy Association.
United Church of Christ.
United Ostomy Association.
Very Special Arts.
World Institute on Disability.

Finally, let me just briefly talk about access to medical care, because I think it is important. We have about 40 million Americans that do not have health insurance. A large percentage of those people are poor, a large percentage are children. We can do a lot more to get those children and those poor people enrolled in the programs that they qualify for than what we are

doing now. Fully half of the children in this country that are uninsured qualify for either Medicaid or for the CHIP program. And we ought to make a better effort to do that. But when we look at providing better access for all Americans to health insurance, we need to be careful that we do not make the situation worse.

There are some ideas that are in a bill that may come to the floor that relate to expanding what are called association health plans or geographic association type health plans, called health marts, that we need to be careful of.

Madam Speaker, I have two letters here from the Blue Cross/Blue Shield organization and the Health Insurance Association of America that I will include for the RECORD.

BLUECROSS BLUESHIELD ASSOCIATION,
Washington, DC, July 13, 1998.

Hon. GREG GANSKE,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE GANSKE: We are writing to express our deep concerns about exempting Association Health Plans (AHPs) and certain Multiple Employer Welfare Arrangements (MEWAs) from state law.

This unwise proposal has surfaced again, this time as part of a package of recommendations from the House Republican health care quality working group. BCBSA is concerned about many of the working group's recommendations, but we are particularly troubled by the AHP/MEWA provision.

For good reason, exempting AHPs/MEWAs from state law is strongly opposed by governors and other state officials, consumer groups, health professionals, major health insurance organizations and some small businesses. This proposal would:

Transfer regulation of these entities from states to an unprepared federal government. The Department of Labor has already testified that it does not now have the resources needed to adequately oversee the ERISA plans already under its purview. Consequently, exempting AHPs/MEWAs from state law would necessitate a substantial increase in federal regulators in order to set and enforce solvency standards and other consumer protections

Increase premiums for many small employers and dramatically hike rates for individuals who purchase their own coverage. By exempting AHPs/MEWAs from state law, the proposal would undermine state reforms that have improved the accessibility and affordability of health coverage, such as risk-spreading laws that assure cross-subsidization between low- and high-cost groups.

Decrease health coverage for those who use the most medical services. The proposal would give AHPs/MEWAs a strong incentive to cover only the healthiest people. As a result, sicker people—who are most in need of coverage—would be left in state-regulated insurance pools. Their premiums would increase as more health people joined AHPs/MEWAs, causing many to lose their health coverage.

Reduce funding for state programs to improve access to health coverage. Because AHPs/MEWAs would be exempt from state law, they would not have to contribute to state programs to improve access (e.g., high-risk pools), which are typically funded by assessments on small group health insurance premiums.

BCBSA shares the concerns of AHP/MEWA supporters who want to make health coverage more affordable for small businesses and others. But this proposal would undermine successful state reforms, increase premiums for many and decrease health coverage for those who need it the most.

When Congress considers the working group's proposal this summer, we urge you to oppose exempting AHPs/MEWAs from state law.

Sincerely,

MARY NELL LEHNHARD,
Senior vice President.
JACK ERICKSEN,
Executive Director, Congressional Relations.

JUNE 4, 1998.

Hon. GREG GANSKE,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE GANSKE: We are writing to express our opposition to proposals that would exempt certain health insurance arrangements, such as association health plan (AHPs) and multiple employer welfare arrangements (MEWAs), from state insurance law and regulatory authority.

We remain very concerned about proposals to preempt state regulatory of federally certified association health plans, including many MEWAs (e.g., H.R. 1515/S. 729). These proposals would undermine the most volatile segments of the insurance market—the individual and small group markets. AHPs could siphon off the healthy (e.g., through selective marketing or by eliminating coverage of certain benefits required by individuals with expensive illnesses), thus leading to significant premium increases for those who remain in the state-regulated pool. The ultimate result: an increase in the uninsured and only the sickest and highest risk individuals remaining in the states' insured market.

We have similar concerns regarding a proposal to create a new type of purchasing entity, called HealthMarts, which has not been reviewed via the committee hearing process. This proposal would exempt health plans offered through a HealthMart from state benefit standards and requirements to pool all small groups for rating purposes. As with AHPs, this proposal raises serious concerns regarding market segmentation and the ability of states to protect their residents. The combination of these two proposals could lead to massive market segmentation and regulatory confusion.

Moreover, these proposals, over time, would lead our nation toward increased federalization of health insurance regulation. Preemption of state regulatory authority would create a regulatory vacuum that would necessitate an exponential increase in federal bureaucracy and federal regulatory authority.

As representatives of the health insurance and health plan community, we are concerned about the issue of access to health coverage for small firms. However, we urge legislators to avoid legislation that unravels the market by helping a limited group of small employers at the expense of other individuals and small groups.

We look forward to an opportunity to work with you regarding proposals that expand coverage without damaging the small group and individual markets.

Sincerely,

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
HEALTH INSURANCE ASSOCIATION OF AMERICA.

Sometimes I agree with the insurance industry. In this situation I do. I think that association health plans can siphon off the healthy. They can thus lead to significant premium increases for those that remain in State-regulated insurance pools.

☐ 2000

The ultimate result could be an increase in the uninsured, and only the sickest and highest risk individuals remaining in the State's insurance market. We have to be very careful about those types of provisions.

Finally, Madam Speaker, let me just say that I appreciate the Speaker of the House, the gentleman from Illinois (Mr. HASTERT), sticking to his word that we are going to have a debate on patient protection legislation next week. I hope that we will have a clean and fair rule that will allow the majority of the House to have its say on passing good, strong patient protection legislation.

I think that we have been working on this for about 4 years. It is a struggle when you are going up against an industry as powerful as the HMO industry. But despite the fact that they have spent about $100 million lobbying against this, money that should, in my opinion, have been spent on care for patients, the public overwhelmingly wants to see Congress pass a strong Patient Bill of Rights, strong patient protection legislation. They have heard from their friends, they have heard from family members, they have heard from fellow employees about problems with people in HMOs getting the kind of care that they should be getting, and they are scared that that could happen to their own family and their own children. They just want a fair chance at reversing an arbitrary denial of care because some of those decisions, as I pointed out in my speech tonight, and countless hundreds or thousands of others that I could talk about have resulted in injury to people, and it is occurring every day that goes by without our having this debate, Madam Speaker.

I encourage my colleagues on both sides of the aisle to join with the 300 endorsing organizations, support H.R. 2723, avoid believing the distortions that the industry is putting out about this bill. The sky will not fall, HMOs will continue. In fact, they will be better HMOs if we pass this legislation.

WHERE WE ARE WITH DRUG POLICY

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

Mr. MICA. Madam Speaker, I am pleased to come back to the floor tonight, and as usual on Tuesday nights, I try to address the House and the American people on the subject of the illegal narcotics situation. As I have stated many times on the floor of the House of Representatives, I take this issue very seriously.

I chair the Subcommittee on Criminal Justice, Drug Policy and Human