has proposed and why his plan to shore up Social Security is much preferable to Governor Bush's, and certainly not risky, by any means.

Because of the administration's commitment to fiscal discipline, as I have mentioned, the Nation's debt is already $1.7 trillion lower than it was projected to be this year. In fact, when the administration took office, by the year 2012 it was projected that 25 cents of every dollar would go to pay the interest on the national debt. That has not happened, because we are now paying down the national debt with the surplus that has been generated.

Vice President GORE is basically saying that he is going to pay off the national debt and help maintain America's prosperity in a number of ways. But what I want to zero in on is how he would dedicate $2.1 trillion for debt reduction, and this is basically to prepare the Nation for the retiring of the baby-boomers.

He is proposing to use more than 95 percent of the Social Security surplus to pay down the debt, with the idea being, of course, that ultimately that will strengthen the economy and prepare for the fact that so many more senior citizens are going to be retiring as part of this baby-boom generation.

After a decade of debt reduction, GORE transfers the interest savings that come from using the Social Security surplus to buy down the debt to strengthen the solvency of the Social Security program. By 2016, GORE will be adding about $250 billion annually to strengthen Social Security until at least 2050.

He is investing $103 billion, less than 5 percent of the surplus, in strengthening Social Security's benefits for older women, because, as we know, poverty among elderly women is a major national challenge. In 1997, poverty among elderly widows was 1 percent, compared to 5 percent for married women. GORE believes that we can and should strengthen benefits for widows and mothers that were penalized for years spent caring for children as part of the plan to extend the solvency of Social Security.

Now, I could talk in more detail about how the Vice President's plan helps older women, but I just want to mention two things, if I could, about that before I conclude this evening. One point is to eliminate the motherhood penalty. The current Social Security formula is based on average earnings over 35 years of work. Because women take several years raising their children, the typical woman only works 27 years. However, those years raising children do not count towards Social Security earnings, effectively creating this motherhood penalty. GORE says that he would eliminate the motherhood penalty by allowing parents to take credit for up to 5 years of earnings, if they take that time to raise children. This would increase Social Security benefits for those women by about $600 a year.

The second thing that GORE would do to strengthen benefits for women, under current law widows can have their combined benefits cut in half. Living costs such as rent and utilities often do not decrease with the death of a spouse, but then there is a cut in benefits to that widow. In fact, single elderly women are four times as likely to be poor as married women. GORE would fight to raise the widow's benefit to three-quarters of the couple's combined benefit, helping more than 3 million elderly women receive a benefit that reflects their cost of living.

I am not going to go in more detail tonight, but I know over the next few weeks, and certainly after the Memorial Day recess, you are going to see myself and other Democrats come to the floor and constantly talk about our concerns with regard to the Bush privatization Social Security plan, because I really believe it is a radical plan, and I do not think the average American or senior understands what it is all about.

This plan, and this is how I want to conclude this evening, the greatest fault in it is the numbers simply do not add up. I think this goes back, again, to the fact that he has this $1 trillion tax cut, and then he is taking all this money out of the Social Security system.

If you take the money out of the surplus for tax cuts, and then you put in effect this risky Social Security plan, it just has too much of a drain on the Federal budget. Taken together, the tax cut and Bush's privatization plan essentially would swallow the whole surplus for the next 10 years, and also use a significant portion of the surplus that is dedicated to Social Security.

The combination of those two large $1 trillion plans and the impact that they would have on the budget would basically not leave any room for other vital priorities. I think, Mr. Speaker, you know that both the Democrats and the Republicans have talked about a Medicare drug benefit. There is no way that there would be any money left in this surplus to pay for a Medicare drug benefit for seniors if we implemented the Bush plan. The money would simply not be there. It just does not add up.

That is not to mention other priorities. Governor Bush has talked about education. Where is the money going to come from to pay for our education priorities, such as money that goes back to the municipalities to pay for extra teachers to bring class size down, or money that would go back to the towns around the country for school construction and renovation? It just does not add up. The money simply is not going to be there.

So that is why I think it is important for me and Democrats, and hopefully Republicans as well, to bring up the truth about this very risky privatization plan that Governor Bush has proposed, because it would not only have a negative impact on Social Security, but would have a negative impact basically on the economy and the Federal budget, and essentially I think what Americans see today as the reasons for our prosperity.

MANAGED CARE REFORM

The SPEAKER pro tempore (Mr. SOUDER). 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 going to discuss managed care reform tonight. It is pertinent that we do this. Back in October this House voted 275 to 151 to pass the Norwood-Dingell-Ganske Patient Protection Act. That is in conference now. Things are going very, very slow.

Mr. Speaker, I remember back at the time of the debate that we had on managed care reform, a lot of our colleagues, primarily on the Republican side of the aisle, but some on the Democratic side of the aisle, said, Well, you know, we ought to just let the free market work this out.

I am happy tonight to have join me in this special order my colleague, the gentleman from California (Mr. CAMPBELL), who has worked so hard on this issue. We are going to discuss in some detail his bill, which will come to the floor tomorrow, the Quality Health Care Coalition Act.

I am going to yield to the gentleman to describe his bill, and then we will talk about various aspects of it.

Mr. CAMPBELL. I appreciate the gentleman yielding.

Mr. Speaker, let me just say, I am so proud to have the support of not only a brilliant man and a great colleague, but a medical doctor in the gentleman from Iowa (Mr. GANSKE). All of us here in the House that have dealt with him know that is the case. When he speaks on issues of patient care, he speaks from knowledge and compassion.

Mr. GANSKE. If the gentleman would yield, since we will be dealing with an issue related to antitrust, I very much appreciate the gentleman's expertise on this issue as a former professor of law at Stanford University and somebody well qualified to talk about the legal aspects of this bill which we are going to be talking about.

Mr. CAMPBELL. Mr. Speaker, I thank the gentleman.

Mr. Speaker, in 1914 the Sherman Act was amended to say that the labor of a human being shall not be an article of commerce. The reason it was amended was to make absolutely clear what I think most people would consider common sense, that cement and steel and petroleum are one thing, but what was quite different was when an individual did not know exactly what it was they needed, they had to go to a professional, and the professional exercised her or his judgment, and, in exercising her or his judgment, really the doctor or the professional was making a decision that the client or the patient

placed in that doctor's hands, and that was not the same thing as cement or steel or petroleum, because the individual did not know what they needed.

The concept of a professional was quite different than the concept of commerce, because the State would regulate the professions and the professions would regulate themselves. They would have a code of ethics. For example, the doctor said that we do not want people advertising cut rate prices, because you run the risk then that some patients will get something that is not the best service because it is cheaper.

Well, that is the concept of a profession, and I respect the concept of a profession. I regret the fact that we lost a sense of that when the antitrust laws were reversed in 1975, not by action of the Congress, but by the Supreme Court in a case, sadly, that came from my profession, the attorneys. In that case the Supreme Court said not only are we going to extent antitrust to attorneys, but we are going to extend antitrust to all the professions.

The height of absurdity, in my judgment, was reached in 1982 when the Supreme Court said that a group of doctors who had band together to keep prices low in Arizona were price fixers and, hence, subject to the per se rules of the antitrust laws.

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I really do think that we can date the decline of the profession of medicine from that 1975 original and 1982 subsequent Supreme Court date, because doctors are suddenly treated under the law as though they were the same as commercial enterprises providing steel or autos or cement.

One of the greatest artifacts of being treated the same as any article of commerce, just as an article of commerce, not a profession anymore; no more respect for the fact that a doctor is licensed and in every instance that I know of, and I am sure there is good and bad, but in every instance that I know of are dedicated individuals trying to prevent disease and cure it; one of the artifacts is that when one bargains with an HMO, it is now against the law for one to do something that is as natural as one can imagine; one is treated as though one has to take the contract or leave it.

The HMO comes up to you, and let us say you are an opthalmologist and let us say you perform cataract surgery and the HMO says, you know, we are not going to exactly say you cannot perform a cataract surgery on patients over 70, but the risk is a lot higher, and you may not get reupped next year; you may not be able to get your contract renewed next year if you perform too many cataract surgeries on patients over 70. Get the idea, Dr. Smith, Dr. Jones?

Dr. Smith says well, I am an opthalmologist. I will decide when the patient can benefit from cataract surgery. They say well, take it or leave it, because Dr. Green over here is the other opthalmologist in town, maybe there are three or four, in several small towns in America there is only one; take it or leave it. Take it or leave it. And if Dr. Smith calls up Dr. Green and says, you know what they just gave me, I think it is outrageous, at that moment, Dr. Smith has violated the antitrust laws per se and is subject to treble damage action, indeed although the Justice Department has not yet put any doctor in jail for this, it is actually a criminal offense.

Mr. GANSKE. Mr. Speaker, reclaiming my time for a moment, as the gentleman mentioned, prior to my coming to Congress, I was a reconstructive surgeon. I took care of women who had cancer operations, farmers who had put their hands into machines, children with birth defects. But when I was elected to Congress, I closed my practice, so I no longer practice, except for going overseas to do some charity work.

So I want to say this because I do not have a personal interest in this legislation. My wife is a physician, but my wife is a salaried physician. So she has an exemption to this prohibition that we are going to be talking about, because for instance, as a salaried physician, she could join a union and collectively bargain. But this is what has happened.

Let us say back in 1993 and 1994, when I was still practicing before being elected to Congress, in Des Moines, Iowa, there were probably seven or eight HMOs that were offering services. None of them controlled such a large market share that they could make or break a practice. So, for instance, if any one of them was behaving irresponsibly, not taking care of their patients properly, I could get on the phone, give them a call and say, I think you are not treating this patient right. I hope you change your mind. You could lobby on behalf of your patient. They might actually listen to you at that time. But what has happened since then?

Mr. Speaker, in the last 5 or 6 years, since 1994, there have been 275 mergers and acquisitions of health plans around the country. So, for instance, in Des Moines, Iowa, essentially there are two HMOs. For instance Blue Cross/Blue Shield in Iowa controls the health care of 98 percent of hospitals and 90 percent of doctors. One insurance company controls the access and cost of health care for 60 percent of insured Oregonians.

Market competition in Texas is all but gone. Mr. Speaker, 24 competing companies have been compressed into 4 mega-managed care companies. Sixty percent of the Pittsburgh market is controlled by one plan. Half of the Philadelphia market is controlled by one plan. Each of those plans maintains its dominance by virtue of an agreement not to compete with each other. One insurance company dictates health care to over half of Washington State. In Seattle, the figure is higher. In eastern Washington, 70 percent of the patients are controlled by one plan.

What does this mean? It means, for instance, that an HMO can devise a contract like this one. We define medical necessity as the short test, least expensive or least intense level of treatment as determined by us, the health plan. Then they can give the physicians, let us say we are talking about eastern Washington where this HMO controls 70 percent of the population. They can give that contract to employees; they can also give a contract to the physicians or the nurses, or, for that matter, the pharmacists, and they can say, take it or leave it.

Now, in the old days, and this is where the market competition comes in that my friend who opposed the managed care reform bill said, well just let the market work. Well, in the old days, you could. You could say, I am sorry, I am not going to sign that contract with you when you define medical necessity that way. But today, if they control 70 percent of the patients and they say take it or leave it, one may be left not being able to pay mortgage payments or pay for your daughter's education. That is tough. That is a tough decision. It could break your practice. It could mean you could no longer practice in eastern Oregon, for example.

So you say, well, what is the problem with signing that contract that has that clause in it?

Let me give an example, and then I will yield back to the gentleman. As a reconstructive surgeon I used to take care of, and I still take care of overseas kids that are born with this type of birth defect, a cleft lip and palate. Under that plan's arbitrary definition in their contract, they could say, we are not going to authorize surgical correction of that huge hole in the roof of this baby's mouth; we are just going to authorize you using a little piece of plastic to shove up in there to close the hole, it is called a plastic obturator. They can do that according to the contract. If I came back to them and I said, that is egregiously wrong; that is keeping this child from being able to learn to speak properly. If I then went to some of my medical colleagues and I started to talk to them about that HMO's practices and we mentioned to each other gee, we do not think that we can support or sign up for an HMO that does that kind of practice, my friend from California, what would happen to us?

Mr. CAMPBELL. Mr. Speaker, you would be sued for treble damages by the insurance company that made the offer to you.

Mr. GANSKE. And what effect would that have on the ability of this child to get this?

Mr. CAMPBELL. Mr. Speaker, if I were the gentleman's attorney, I would advise the gentleman not to treat that child, because he would run the risk not only of financial damage, but he also might run the risk of a conviction,

and a conviction even of a misdemeanor is, in many States, sufficient to disqualify one to practice medicine.

Mr. GANSKE. Mr. Speaker, let me continue then about another type of contract provision that HMOs force on providers, and that is what is called gag rules. That is where, for instance, Aetna has said, providers shall not provide or threaten to provide inferior care or imply to members that their care or access to care will be inferior due to source of payment.

In other words, there are some HMOs that say, before you can tell a patient all of their treatment options, you must first get an okay from us. And if you do not do that, we are going to deselect you from our plan. If our plan happens to cover 50 percent of your patients, tough luck.

The point is this: by using their market share, they have a huge amount of leverage on the individual practitioners that can then significantly interfere with the physician in his professional duty of being the advocate for the patient.

Mr. CAMPBELL. Mr. Speaker, if the gentleman would yield, that example is even worse than the first. One's obligation as a physician to advise a patient on what the patient's best choice of treatment should be seems to me paramount and ought to be untouchable. Yet, what we have allowed to develop in this country, through contract, not through any Federal law, but through contract and the force of power of the HMO or the insurance company on the other side of the contract, is that you do not offer that advice. You are gagged. You are subject to the gag rule.

Mr. GANSKE. Mr. Speaker, reclaiming my time, what happens then? The company uses its ability to gag you or deny necessary care, and so you have a baby born with that birth defect that does not get the treatment that they need.

Mr. CAMPBELL. Would the gentleman yield?

Mr. GANSKE. I yield to the gentleman.

Mr. CAMPBELL. Mr. Speaker, it is most galling that this situation persists because the insurance company has an antitrust exemption, and what we are trying to do in the bill that we will vote on tomorrow is to say that a medical doctor ought to be treated no worse than the insurance company on the other side of the bargaining table. What happened is remarkably fascinating to the situation at hand.

Mr. Speaker, the Supreme Court said that insurance was not subject to the antitrust laws for about 50 years, and then in the 1940s, they held that it did apply. Do my colleagues know how long it took before the insurance industry got an exemption from insurance from antitrust through this Congress? It took less than 2 years. And so today, we are left with insurance having an antitrust exemption to the extent that it is regulated by State law, the business of insurance is exempt from antitrust.

Mr. GANSKE. Mr. Speaker, let me get this straight, reclaiming my time. So while the insurance industry is critical of the bill, they, at the same time, have an antitrust exemption. Is that right?

Mr. CAMPBELL. Mr. Speaker, the gentleman is quite right. In fact, they ought to consider emulation is the highest form of flattery. They came to Congress and got an exemption from antitrust for their industry and they begrudge those who they say are exploiting on the other side of the bargaining table.

Mr. Speaker, I go back to the example of take it or leave it. Take it or leave it was something that employers used to say to employees too, and the employees said, I am not taking it. I am joining the union. In 1914, the Clayton Act was passed that created an exemption from antitrust for labor unions for exactly the same reason, that it was not fair for the powerful employer in a particular area to say, take it or leave it. Even worse is the insurance company, because the employer would have market power just by reason of being large; the insurance company has market power in some instances because of the antitrust exemption. So in the case of labor, if a doctor is a member of a labor union, the doctor can say, no, I am not taking it or leaving it, and neither is my brother and neither is my sister.

What we are trying to do in this bill is not force every doctor to join a labor union. Indeed, this bill is quite explicit. It does not touch the question of a doctor being in a labor union; it explicitly says the bill gives no right to any doctor to strike, but it says one very important thing, that the doctor or the medical professional shall be allowed the same degree as though they were in a labor union an exemption from the antitrust laws solely in the context of bargaining, just getting the terms of that contract so that one can treat that child with a cleft palate, so that one can communicate with one's patient and tell her or him all of the options available.

Mr. GANSKE. Mr. Speaker, reclaiming my time, practically speaking, what has happened is this: we have seen a number of HMO abuses around the country. Eighty percent of the public thinks that Congress should do something to fix this problem. Almost everybody knows a friend or a family member or a fellow worker, an employee who has not been treated fairly and gotten the type of treatment that they need. There are two approaches to fixing this.

The first approach is a regulatory approach.

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When Congress took away from the States for employer plans the ability to oversee the quality of those health plans, those insurance plans through the Employee Retirement Income Security Act, it basically left a vacuum. It did not fill in that traditional State oversight by a State insurance commissioner, and so people, most of the people in this country who are working get their insurance from their employer. Most of them are surprised to know that if their State legislature has passed some type of patient protection, it probably does not even apply to them.

So what we did back in October was, we started to fill in the gaps in terms of patients being treated with due process, the regulatory gap at the Federal level. But we had a lot of comment on that. People said, well, you know, maybe we just ought to let the market work better.

Well, what we are talking about tonight is that because of market concentration where we now essentially have six large HMOs in the country, the free market is not working right. I mean, the gentleman could probably give me analogies better to what it was like for a farmer having to deal with a railroad monopoly.

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

Mr. GANSKE. I yield to the gentleman from California.

Mr. CAMPBELL. Mr. Speaker, the gentleman makes an excellent point, because this is another example, it is called the Capper-Volstead Act, and the farmers of the United States have an antitrust exemption. And the reason was that Congress was scared, worried, troubled that the great purchasers, the railroad cooperative or the purchaser, I hesitate to use a company name, but let me say in the past what you might have called Cargill or Archer Daniels & Midland, I am not in the slightest alleging that they are engaged in exploitative practices now or that they ever were specifically, but use them as an example, a large purchaser might be able to tell the farmer, hey, we are not buying your crop, go put it back in the ground.

Mr. GANSKE. Reclaiming my time, I believe there have also been some antitrust exemptions for fisherman.

Mr. CAMPBELL. For the same reason, the Fisherman's Cooperative Antitrust Exemption Act, because once you catch the fish, you cannot put them back in the ocean and hope to collect them again. And what is common, whether we are speaking about the labor union or the farmer or the fisherman, is that there is unequal bargaining power, because the other purchaser, the other side of the contract, the purchaser is able to say take it or leave it.

What has been done with Congress in every instance that we have been through here, that we have been explaining, it is fair for the other side to present a united front, whether it is the employee facing the employer in the company town, whether it is the single purchaser of the fish or the large purchaser of the grain, and what is proposed in this bill is to do, even, more

importantly, for an industry that faces an insurer, which as the gentleman has so wisely observed is increasingly concentrated market power in some particular geographic markets. I know the gentleman can give examples that are in the 90 and 95 percent range, but also with an antitrust exemption.

Let me say this is completely in keeping with the other antitrust exemptions that we have created in the context of unequal bargaining power. But it is more narrow than virtually any of them, because it only will extend to the process of bargaining. It does not, for example in insurance, say the business of insurance is hereby exempt to the extent it is regulated by State law. That is a huge exemption.

This bill will only exempt in the context of negotiating the medical professional who joins with another medical professional to tell the HMO we speak as one.

Mr. GANSKE. Reclaiming my time, let us go back to this for a minute. Let us say you have a family practitioner out in a small rural town and he knows of some examples where this HMO has not treated his patients fairly; and he says, you know, I think also possibly through specific contract provisions as they relate to his relationship with the HMO, that, for instance, might gag him from telling the patients about their illnesses, if he says to that large insurer, you know, I think you ought to change that, but 80 percent or 50 percent of his patients are in that, do you think that that large insurer is going to bargain with them, is going to change their contract with him? No. They are going to say, as the gentleman said, take it or leave it.

Mr. CAMPBELL. They will go next door.

Mr. GANSKE. They will go next door, and so what we are looking at is an ability, and I think this is crucial, the gentleman has it in your bill, and we have to repeat this, the gentleman has in his bill a prohibition on strikes.

Mr. CAMPBELL. Absolutely.

Mr. GANSKE. Let us repeat that.

Mr. CAMPBELL. There is a clear statement in the bill that there is no right to strike conferred by this bill.

Mr. GANSKE. So that nobody tomorrow when we debate this can say that doctors, if we pass this bill, the Campbell bill will allow physicians to go on strike; is that right?

Mr. CAMPBELL. That is right, no one can say that truthfully tomorrow.

Mr. GANSKE. That is a good point. Now, what we are talking about then is for a group of physicians, for instance, that have seen abuses by that HMO to be able to get together, possibly to hire somebody to negotiate for them to go to that HMO and correct some of the abuses that they are seeing, and, say, look, as a group now, they have more equality in terms of this bargaining position. We want you to treat patients more fairly when, for instance, they go to the emergency room.

Mr. CAMPBELL. Great example. I say to the gentleman, ought there not be some understanding that the HMO will cover the costs in the emergency room closest to the accident? Ought this not be a minimum sort of situation, and if a doctor insists on that and says I am sorry, we are not going to put that in your contract, take it or leave it, who cares more for the patient, the doctor who is the trained professional committed to a code of conduct regulated sternly by the State and by her or his own colleagues in caring for the patient, or the HMO. And I am not saying that they are all bad; I am not saying that they are most bad. But I am saying that they are differently motivated.

Mr. GANSKE. Reclaiming my time, what we are dealing with is a situation, for instance, where it may not be a matter that is specifically in the contract that the physician has, but he knows that there are provisions in the contract that an employee might have that are preventing the patient from getting the needed care in an emergency.

I will give my colleagues one example here. We have a little boy here who is 6 months old. One night about 3:00 in the morning, he had a temperature of about 104, 105. The mother and father lived south of Atlanta, Georgia. His mother gets on the 1–800 HMO number line, talks to somebody a thousand miles away, says my baby Jimmy has a temperature. He is really sick. He needs to go to the emergency room.

The HMO reviewer, who has never examined the child, says, well, I guess I could authorize you to go to an emergency room, but the only emergency room we are going to authorize is one that is 70 miles away, 70 miles away. And if you go to any other one, then you can pay for it yourself. So Mom and Dad wrap up little Jimmy. They get in the car; they start their drive. 20 miles or 30 miles into the drive, they pass three emergency rooms that they should have been able to stop at, because Jimmy was really sick; but they were not health professionals, they did not know how sick he was.

Before they got to the designated hospital, he has a cardiac arrest. Imagine, Dad's driving this little baby frantically, mother is trying to keep him alive. He is not breathing any more. His heart is not going. They finally screech into an emergency room. Mother leaps out of the car, screaming save my baby, save my baby. A nurse comes running out of the emergency room, gives him mouth to mouth resuscitation.

They start an IV. They start medicines and somehow they get him back to life, but they were not able to save all of this little baby, because he ended up with gangrene in both hands and both feet as a consequence of that HMO's decision. He ends up having to have both hands and both feet amputated.

Now, the point of the gentleman's bill I say to the gentleman is this. Let us say I am the family doctor, and I find out that this HMO has treated my patient this way, and I hear from some other fellow physicians that they have done the same thing; and we say, you know, we are not incorporated together. We are not salaried physicians. We are just individual physicians out there, but we know there is a problem with this HMO, the way they are treating babies like this.

We say to the HMO, unless you change your emergency room policy, we are not going to sign up with you. Under current law, that group of doctors advocating on behalf of their patient could be sued under antitrust. Is that not right?

Mr. CAMPBELL. It is absolutely right. I say to the gentleman, they could be sued by the Federal Trade Commission. They could be sued by the Department of Justice. They could also be sued by the HMO, which would calculate for the year, let us say, how much additional costs the HMO had to pay out over what the contract would have been if they had only access to the emergency room 70 miles away, and multiply that additional cost by three, it is trouble damages in antitrust, plus the HMO would get its attorneys fees, because prevailing plaintiffs, not prevailing defendants, only prevailing plaintiffs get their attorneys fees in antitrust.

Mr. GANSKE. Let us deal with some of the myths about the Campbell bill. Some people say that this would allow price fixing. I wonder if the gentleman would like to address that issue.

Mr. CAMPBELL. Well, indeed, when we are speaking about doctors presenting a united front, it is going to impact the compensation that they get. It just has to. If you are a family physician and you are being forced to accept a per-patient capitated rate, that means you see 20 patients per hour, you are not the same family physician that you wanted to be when you graduated from medical school. And in most instances, you are not really adequately providing health care.

It is impossible, impossible to divide the question of compensation from the question of care. That, however, leaves us open to criticism by the unfair, to create traps for those who would use the trap. It is unavoidable if you are going to get better care that you are going to have to have some payment for the better care. You cannot repeal the law of economics any more than you can repeal the law of physics.

Mr. GANSKE. What the gentleman is saying is that some may try to narrow the law to only deal with nonfiduciary matters, but I believe what the gentleman is saying is that an HMO can set a fee so low as to effectively deny the treatment.

Mr. CAMPBELL. The gentleman is absolutely right. And we anticipate an amendment to this extent being offered tomorrow. And on its first blush, it will sound good. It will say none of this antitrust immunity shall extend to the question of compensation. It is, however, a gutting amendment, a killer

amendment. What it would do is leave virtually nothing, because virtually nothing that we speak about here tonight is unrelated to the question of compensation. So that is a very important point to make clear.

Mr. GANSKE. I go overseas and I do cleft lip and palate operations in Third World countries where the families cannot afford it. But I will tell you what, people are spending an awful lot of money in this country for their health insurance. It ought to mean something when they actually get sick and need it, for instance, a child. And it ought to be covered at a level that would not preclude a person from getting it.

But I want to go back to one thing, and that is that under the gentleman's bill, price fixing or fee setting by physicians is still illegal, and that is because what we are talking about is a group of physicians being able to negotiate with an HMO, but we are not talking about that group of physicians being able to set fees across the board. Is that not correct?

Mr. CAMPBELL. The gentleman is absolutely right. The extent of the immunity is in the context of bargaining. And even today, I heard a related myth, that this will be a wholesale antitrust exemption and would allow doctors to join in a boycott, a boycott of a particular pharmaceutical company, Merck was mentioned because it was in the news, the argument about price fixing, the argument that doctors could get together and agree that no nurse anesthetist would practice.

Those are all false. The exemption is specific to the practice only of bargaining; and to make it even more clear, we added an amendment that even in the context of bargaining it shall not be permitted as an exemption from the antitrust laws to agree to exclude any other professional from their scope of conduct, and we have our colleague from the other side of aisle, the gentleman from New York (Mr. NADLER), to thank for working out that amendment. The Nadler amendment is part of this bill. So price fixing at the patient level, not permitted. Exclusion of other professionals, not permitted. Barring the doctor's right to choose a pharmaceutical of his or her choice, not permitted. And, yet, I suspect in fear, we will hear about those tomorrow.

Indeed, with my colleagues' indulgence, let me say that I woke to a fascinating circumstance yesterday. I heard my name mentioned in an ad on the local radio station in Washington D.C. And I had no idea I was so evil, but the Campbell bill was being described as OPEC for doctors, and this is actually the first thing I heard after waking up. The Campbell bill is OPEC for doctors; call your Congressman and oppose the Campbell bill.

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Well, being Campbell, this did get me out of bed very quickly.

My own view, is that, as I described, OPEC is the scariest cartel because Americans know about price-fixing by petroleum companies. This bill is restricted to the bargaining context. And I am grateful, I suppose, that people are mentioning my name, and hopefully they will spell it right, but I am not running for office in the District of Columbia.

Mr. GANSKE. Reclaiming my time, I have to laugh that they are calling this bill a doctors cartel, because when we look at the oil cartel, we have 11 OPEC countries controlling the cost and access of 40 percent of the world's oil. What we have in this country is we have a managed care cartel where seven giant insurers and the Blues control costs and access of over 50 percent of the U.S. health care market. OPEC nations utilize their oil production policies to control the market, the price and the profit of oil. And that is exactly what the managed care cartel does.

But I think we should also go onto this issue of, well, is the Campbell bill just going to mean that physicians are going to become unionized. I find this the most amazing misunderstanding of the gentleman's bill, because the gentleman's bill, H.R. 1304, would allow physicians and other health care professionals to negotiate with insurers without forming a union.

Let me tell my colleagues on the Republican side of the aisle that if they want to see physicians become a union, then they should vote against the Campbell bill. Because if we take those physicians out there in those small communities where they are just squished in any type of consumer care problems with the HMOs, and the only recourse they have is to join a health group and become salaried physician, then in that circumstance, under the current law, then they can form a union.

If we do not pass the Campbell bill, I will make a prediction. I will predict that we will see an acceleration of physicians into unions. The Campbell bill is a preventive piece of medicine in terms of physicians becoming unionized.

Mr. CAMPBELL. I am pleased that the gentleman made it very clear, particularly for our colleagues on the Republican side. I want to add a word for our colleagues on the Democratic side, however, as well.

I have been very pleased with the support that we have had from several unions who have said, even though this undercuts the attractiveness of a union, we recognize and we are happy to see the benefit of collective bargaining. And we have actually had support from the American Federation of State, County, Municipal Employees Union for that concept. So to make it clear, it actually provides some of the benefits of being in a union and, hence, makes it less attractive to be in a union.

Nevertheless, it is my delight to report that it is supported by over 100 Democrats as well as just under 100 Republicans. We have about 90 Republican cosponsors and about 120 Democrats.

May I say one extra thing, too, at this moment, because it is important. The American Medical Association is supporting the bill. So also is the National Medical Association. And let me just take a moment on that. The National Medical Association was organized as an alternative for medical doctors of the African American race. That was its origin. And there are parts of our history in this area, as in so many others, where there was the practice of discrimination. It has been a source of great pride and support to me that the medical association most connected with increasing the prominence and opportunity for African Americans in our country has endorsed this bill.

Their president has testified in favor of this bill; and he believes, and has said in testimony, that this will yield increased quality of service in those communities that may not get the maximum attention. So on the question of, let me say the traditional issues of importance to all of us, but sometimes more identified on the Democratic side, we are proud of the support that we have.

Would the gentleman indulge me one second.

Mr. GANSKE. I wonder if the gentleman would address the issue, because I am sure we will hear about this tomorrow, the issue of the cost of the gentleman's bill. I know there was an initial Congressional Budget Office analysis of the bill which was incorrect in several of their assumptions, and I will bet the gentleman can fill me in on the details of that.

Mr. CAMPBELL. Well, indeed. What reminds me of this was the radio advertisement that I referred to. The advertisement now running in Washington, D.C., says that one estimate says that this will increase cost 15 percent. No, that is not correct.

The Congressional Budget Office assessment is that the ultimate effect to the patient will be six-tenth's of 1 percent. Six-tenth's of 1 percent. Now, I have good reason to believe that is wrong because they do not measure quality. And if quality is improving, which it surely will under this bill, any measurement of cost-per-unit quality will likely drop.

But let me explain how 15 percent came to be. The Congressional Budget Office said, well, we have to make some assumption as to what the initial increase in compensation to the doctors will be. Let us just assume that the studies of industrial unions, which show that members of industrial unions make roughly 15 percent more than individuals in that same calling who are not members of industrial unions, let us assume 15 percent.

Mr. Speaker, it was done on no more basis than that. But it started there, and then it came down to six-tenth's of 1 percent after figuring the following.

Even assuming that 15 percent increase goes to the medical professional, the next step is the HMO. And the HMO is going to take a hit to its profit. I do not deny that, and I do not apologize for it. And as it does, that eats up some of the proposed increase in cost. Then the HMO has a certain amount it passes along to the employer, and the employer takes a certain amount of that in her or his profit. And then the employer passes along a certain amount of it to the employee. And by the time it gets down to the employee, the Congressional Budget Office estimate was six-tenth's of 1 percent.

Mr. GANSKE. Okay. So they originally said that the cost was going to be how much?

Mr. CAMPBELL. They said that the reimbursement to the physician was 15 percent. But their original estimate of the cost was 2 percent, and I pointed out a couple of errors in their analysis.

Mr. GANSKE. And now the CBO is saying that the cost would be six-tenths of 1 percent.

Mr. CAMPBELL. Six-tenths of 1 percent.

Mr. GANSKE. Six-tenths of 1 percent. And I would point out that that is probably an accurate figure. I think that there would be a very small increase. And the reason why there would be a very small increase is because, quite frankly, when groups of physicians get together to negotiate with those HMOs, especially concerning those consumer practices that affect whether a patient can get the type of treatment that they need, let us say on the medical-necessity issue, then I think there would be a little bit of an increase in cost because, quite frankly, I think a lot of HMOs have been denying appropriate care, and that care is going to cost a little bit more.

But the fact of the matter is that we can, if we treat people appropriately and fairly, and they get the type of treatment that they need at an appropriate time, then, in the long run, I think we can prevent not just additional expenses to the medical system, but we can also prevent disasters like happened to this little boy when he lost his hands and feet. And how do we calculate what his hands and feet are going to be worth to him the rest of his life?

Mr. CAMPBELL. There is one other aspect, if the gentleman will yield, on the question of cost. But I cannot leave the gentleman's previous example without saying he is absolutely right. And for those whose only focus is cost, they will forever be subject to the predatory activities of those who offer a quality that is diminished.

But the other aspect of the cost estimate is the CBO, in coming to the six-tenths of 1 percent, did not include the following consideration: that as dealing with HMOs becomes a little bit fairer and a little bit more enjoyable and a little bit more professional for the medical doctor, we will see doctors staying in HMOs who otherwise would have left them.

It is true that the HMO is a lower cost effect delivery than fee-for-service has been. And so as we have more doctors going into HMOs because it is a more hospitable environment, we will actually have a depressing effect on cost. That I pointed out, but the CBO did not include in its estimate.

So I think we can safely conclude two things: one, that the cost increase to the patient is going to be very, very small. And I will accept the six-tenths of 1 percent, as does the gentleman. But, secondly, that estimate has not considered quality. And there are many points where we simply cannot measure quality in dollars and cents. But taking the most conservative assessments, the quality increase is worth it.

Mr. GANSKE. I wonder if the gentleman would care to comment on the opposition of the Federal Trade Commission and the Department of Justice.

Mr. CAMPBELL. I had the honor to be director of the Bureau of Competition, Federal Trade Commission, during the administration of President Ronald Reagan. As a result, I am an FTC graduate. I used to bring antitrust lawsuits on behalf of the Federal Trade Commission. And the Federal Trade Commission, to my knowledge, has opposed every exemption from the antitrust laws ever proposed. I do not run the risk of being corrected on that.

I remember testifying before Congress, when I was the director of the Bureau of Competition, for a limitation on the antitrust exemption for ocean shipping. In each case, the FTC and the Department of Justice do exactly what we would expect of them, and I do not fault them at all.

Mr. GANSKE. They are protecting their turf.

Mr. CAMPBELL. That might be a doctor's assessment of a lawyer. A lawyer might say defending his jurisdiction. Protecting his turf sounds like the same thing.

Mr. GANSKE. I wonder if the gentleman would care to comment on the fact that the Department of Justice did not challenge a single health care merger in the last decade of all these HMOs, while the 18 largest health plans merged into just six, at least not until one of the health groups pushed the DOJ to look at the issue, and then I think they went ahead and granted the merger anyway. Would the gentleman care to comment on that?

Mr. CAMPBELL. Indeed, I was in charge of the aspects of merger analysis that was applied by the Federal Trade Commission. And, roughly speaking, and this is ballpark but it is about right, up until 40, 50 percent market share is achieved in a merger, the FTC and the Department of Justice will permit the merger.

It is actually more complex than that. It is done under an index called the Herfindahl-Hirschman Index. But the FTC and Justice will oftentimes make an analysis of will there be potential competition. Will another hospital enter if the existing merged entity extracts a higher price. And in so doing, the patients might suffer for a year or two until that new entrant happens. The analysis, in other words, allows a substantial accumulation of market share.

I find myself admiring the analysis that involves economics at the Federal Trade Commission and not admiring the outcomes that, at least in this instance, allowed the accumulation of market power. The theories might have been right; but the practice, as we have seen, did not result in consumer benefit.

Mr. GANSKE. Now, some people say that H.R. 1304 will come under the National Labor Relations Act. Is there anything in the gentleman's bill that has to do with the National Labor Relations Act?

Mr. CAMPBELL. Only the one sentence in the bill that it does not come under the National Labor Relations Act. I explicitly put into the bill a statement that nothing in this bill shall alter in the slightest the application of the National Labor Relations Act or extend to areas which previously it did not extend to. Absolutely false. Not a change.

And I will put to the gentleman something he and all of us in the House know. If there were any such implication, the bill would have been referred to the Committee on Education and the Workforce, which is jealous of its jurisdiction, and it was not. It was kept in Judiciary, dealing strictly with antitrust.

Mr. GANSKE. Now, the gentleman has wide bipartisan support of this bill. How many cosponsors does the gentleman have for this bill?

Mr. CAMPBELL. I am proud to say we have 220 cosponsors. And as everyone here knows, 218 is a majority of the House. Of those 220, as I said, just under 100 are Republicans and the rest, slightly more, are Democrats.

Mr. GANSKE. So it would be the gentleman's contention that since Congress is indicating now that they think that there is a problem, our leadership does too, that there is a problem with HMO abuses, that for those who think, well, let the market do its will, the market has to be able to do its will.

Mr. CAMPBELL. Right. And we cannot have an antitrust exemption on one side and individuals unable even to call each other on the other. And market power with fewer and fewer HMOs on one side, and a doctor who cannot even express her or his revulsion against a gag order to her or his colleague, is not the market.

I suppose if one were a real free market Ricardo economist, they might say, let us go back to the state of nature. Let us get rid of the antitrust exemption for insurance. Incidently, I actually offered that once, and it got one vote in the Committee on the Judiciary in 1989.

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Mr. GANSKE. I know that I have many friends who will say, well, you know, maybe we do not need to deal with this issue right now because, after all, the Managed Care Reform Act of 1999 that passed the House is now in conference with the Senate and maybe we just ought to wait and see what happens on that conference.

My personal opinion on this is I think we probably need both. I think we need to see some regulatory oversight in the vacuum that was created by ERISA. I think we would probably need less of that if the Campbell bill passed. I do not see them as exclusive of each other.

Furthermore, I would say this: The managed care industry is very creative. We have no way of knowing how they will change their contracts, how they will change their business practices, and what kind of quality issues will arise out of that in the next few years. And that is why I would say H.R. 1304 would address this issue because it would enable the health care providers who are having to deal with this, who are having to stand up and advocate for their patients at that time to be able to band together and advocate for those patients as new permeations arise within the industry.

Mr. CAMPBELL. Mr. Speaker, I appreciate the point of the gentleman. As I said at the start, I admire his compassion, his knowledge, his medical as well as congressional experience.

I took a slightly different view, as the gentleman knows on the Patients' Bill of Rights. So it is fascinating, here we are with two different positions on the Patients' Bill of Rights.

Mr. GANSKE. Yes, Mr. Speaker, I am supporting the gentleman on his bill. I wish he would have supported me on mine, but he did not. But I understand the commitment of the gentleman when I asked him to support the bill he said I want to approach this from a different aspect, I want to try to make that market work, but in order for a market to work, you have to have fairness in terms of the bargaining positions of the participants.

Mr. CAMPBELL. That is exactly right. And I do have ultimate trust that market solutions are better than Government-imposed solutions. And so, if we pass H.R. 1304 tomorrow and the other body passes it and the President signs it into law, we will have the opportunity to let that private ordering between the insurer and doctor prevail.

My hesitation was the Federal Government seldom gets it right, and having Government put in terms of contracts certainly is offered as an alternative but it is an alternative I would go to as the last one rather than the first.

Might I ask my colleague to yield on one last point, which is the amendment that will be offered by our friend the gentleman from Florida (Mr. STEARNS)?

Mr. GANSKE. Mr. Speaker, I yield to the gentleman.

Mr. CAMPBELL. Mr. Speaker, first of all, the gentleman from Florida (Mr. STEARNS) is a colleague of mine. We entered Congress the same year. So I have high regard for him, but I also have a friendship for him.

The amendment he offers tomorrow, however, is a killing amendment. I just want to draw attention to this. It says that all of this may be well and good, however, the Federal Trade Commission shall have the authority to vitiate any contract reached after such process if in the Federal Trade Commission's opinion that contract does not enhance patient welfare.

If my colleague sees my point, it is directly against the principle I just announced. Here is a Federal Government agency, which does not want this bill, which has been hostile to the concept that medicine should be a perceived as a profession rather than the subject of antitrust to be given the power to vitiate any contract upon its own determination that the particular contract, and here the judgment is not an economic one but a social one, does not enhance patient welfare.

It is a killer amendment. In fact, it goes much farther than an amendment which was offered by our friend from Indiana in the committee, which said they have got to get approval from the FTC first. The theory there was let the FTC sign on or not and give them the yes or no in any particular case.

Well, once again, we know pretty much what the FTC did. Here is the power to vitiate any contract the FTC chooses to decide that it does not benefit health care in its own essentially unreviewable discretion.

So I say to my colleagues who might be listening or to their constituents who might wish to advise them, if they feel this bill is not good, of course vote against it, but it would be disappointing to vote in favor of the amendment being offered by our friend from Florida (Mr. STEARNS) thinking it is improving the bill when in reality it is killing the bill. Vote up or down on the merits. Do not kill by subtle amendment.

Mr. GANSKE. Let me just go back to the nitty-gritty of the bill, and that is that physicians cannot sue under this bill.

The most recent cost estimates by the Congressional Budget Office are six-tenths of one percent. What we are talking about is a group of physicians who do not join a labor union but are concerned about HMO practices who want to get together and tell that HMO, you know, the contract that you are giving those employees for that company where it says ''medical necessity'' means the shortest, least expensive, or least intense level of care is just not right and, together as a group, we will not sign onto a health plan where you are treating one of your subscribers in that way or, for instance, when you have provisions in your contract that says first we have to phone you before we can even tell a patient about their treatment options.

I mean, this affects real-life people and the ability of a physician to be an advocate for your patient.

This is a lady who was profiled in Time Magazine. She had received a recommendation for treatment. She lived in California, the home State of my colleague. She had received a recommendation for treatment from her HMO. The HMO referred her to a medical center, which I will not name, and then put undue pressure on that medical center to deny her the treatment and not tell her all of her treatment options.

She died because of that practice. This little girl and that little boy and her husband now no longer have a mother or a wife because of that. But we have a situation now where if a group of physicians or nurses or pharmacists or other health care providers, professionals, wanted to get together to try to effect changes and to negotiate with an HMO to stop those kinds of practices, unless they were salaried, then they could be brought to court for an antitrust violation.

I just find that that is terribly, terribly wrong. And I know that this happens. I know from practice that physicians are very, very careful about sharing information of misadventures of other HMOs for exactly this reason. Because if they get together and start talking about it sort of as a group, even if it is done on an individual basis, they decide, I am not going to renew that contract, then they could get hit with a big antitrust.

But the fact of the matter is that now they are not even given that choice in many examples anymore because of the concentration in the industry, it may very well mean that they have just lost half of their patients without being able to effect any negotiations with any reasonable chance of success on that; and that may mean, in effect, that they can no longer practice in that community.

Mr. CAMPBELL. I have just received a signal that we have only 2 minutes left. So I simply want to say in about 10 seconds that the whole purpose behind H.R. 1304 is to allow medical professionals to practice their profession so that they can help their patients and that what has happened is that decision has in large part been taken away from them and that is what we wish to correct.

I thank the gentleman for sharing his hour with me.

Mr. GANSKE. Mr. Speaker, I appreciate very much the gentleman from California (Mr. CAMPBELL) joining me in this discussion on his bill, which will reach the floor tomorrow morning at about 9 o'clock. We will have a couple hours of debate on it.

I will encourage all of our colleagues who have cosponsored this legislation to vote against any weakening amendments and to vote for the bill, as my colleagues have indicated they would in cosponsoring this legislation.