

the United States of America who served as Governor of the State of Connecticut in her own right, and she knew Bella Abzug because they served together in the Congress, and Ella died earlier than she should have died. She died of cancer when she was Governor of the State of Connecticut. And of course Ella was Governor, and I do not even think Bella was Congresswoman at that time. But I can remember I was Secretary of the State of Connecticut, and I was very involved in Ella's funeral, and there was not a lot of Congress people at Ella's funeral. But guess what? Bella Abzug came to Ella's funeral. She understood a good woman. And I am standing here tonight telling you we had a wonderful woman with Bella Abzug, and I say with sadness, but with great pride, we needed her when we had her, we will miss her.

Bella Abzug, I loved you. I just hope I can do as much as you want me to do

HMO CRISIS IN AMERICA

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

Mr. GANSKE. Mr. Speaker, 2 years ago I met a woman who killed a man. I did not meet her in prison; she was not on parole. She had never even been investigated by the police. In fact, for causing the death of a man she received congratulations from her colleagues and moved up the corporate ladder.

The woman, Dr. Linda Peeno, was working as a medical reviewer at an HMO. In testimony before the Committee on Commerce on May 30, 1996, she confessed that her decision as an HMO reviewer to deny payment for a lifesaving operation led to the preventable death of a man she had never met.

Since then Dr. Peeno has regretted her HMO deeds every day of her life. In contrition she has blown the whistle on the ways that HMOs deny payment for health services. She showed how plans draft contract language to restrict access to benefits. She showed how HMOs cherry-pick healthy patients, and she showed how HMOs use technicalities to deny necessary care.

□ 2000

Dr. Peeno also told Congress about the most powerful weapon in an HMO's arsenal; to hold down costs. HMOs generally agree to cover all services that are deemed "medically necessary." But because that decision is made by HMO bureaucrats, not by the treating physician, Dr. Peeno called it "the smart bomb of cost containment."

Hailed initially as a great breakthrough in holding down health costs, the painful consequences of the managed care revolution are being revealed. Stories from the inside, like those told by Dr. Peeno, are shaking the public's confidence in managed care. You can now read about some of

Dr. Peeno's experiences in the March 9 edition of U.S. News & World Report.

The HMO revelations have gotten so bad that the health plans themselves are running ads touting the fact that they are different from the bad HMOs that don't allow their subscribers their choice of doctors, or who interfere with their doctors practicing good medicine.

Here in Washington one add says, "We don't put unreasonable restrictions on our doctors. We don't tell them that they can't send you to a specialist."

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

In Baltimore, the Preferred Health Network ad states, "As your average health plan, cost controls are regulated by administrators. At PHN, doctors are responsible for controlling costs."

This goes to prove that even HMOs know that there are more than a few rotten apples in the barrel. The HMO industry has earned a reputation with the public that is so bad that only tobacco companies are held in lower esteem.

Let me cite a few statistics. A national survey shows that far more Americans have a negative view of managed care than a positive view. By more than 2 to 1, Americans support more government regulation of HMOs.

The survey shows that only 44 percent of Americans think that managed care is a good thing. Do you want proof? Well, recently I saw the movie, "As Good As It Gets." When Academy Award winner Helen Hunt expressed an expletive about the lack of care her asthmatic son gets from her HMO, people in the audience clapped and cheered. It was by far the biggest applause line of the movie.

No doubt the audience's reaction was fueled by dozens of articles and news stories highly critical of managed care, and also fueled by real live experiences.

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

Citing a study on end-of-life care, he wrote, "This would seem to prove the popular suspicion that HMO operators are heartless swine."

The New York Post ran a week-long series on managed care. Headlines included, "HMOs' cruel rules leave her dying for the doc she needs."

Another headline blared out, "Ex-New Yorker is told get castrated so we can save."

Or this one, "What his parent didn't know about HMOs may have killed this baby."

Or how about the 29-year-old cancer patient whose HMO would not pay for his treatments. Instead, the HMO case manager told him to hold a "fund-raiser." A fund-raiser.

Mr. Speaker, I certainly hope that campaign finance reform will not stymie this man's chance to get his cancer treatment.

To save money, some HMOs have erected increasingly steep barriers to

proper medical care. These include complex utilization review procedures, computer programs that are stingy about approving care, medical directors willing to play fast and loose with the term "medically necessary."

Consumers who disagree with these decisions are forced to work their way through Byzantine appeals processes which usually excel at complexity, but generally fall short in terms of fairness, and these appeals, unfortunately, Mr. Speaker, sometimes last longer than the patient.

The public understands the kind of barriers they face in getting needed care. Republican pollster, Frank Luntz, recently held a focus group in Maryland, and this is what consumers said. One participant complained, I have a new doctor every year. Another said she is afraid that "if something major happened, I won't be covered." A third attendee griped that he had to take off work twice because the plan required people to see the primary care doctor before seeing his specialist.

Those fears are vividly reflected in editorial page cartoons. Here is one that reflects what that focus group was talking about. It shows a woman working in a cubicle in the claims department of an HMO. In talking to a customer she remarks, no, we don't authorize that specialist. No, we don't cover that operation. No, we don't pay for that medication. She is then surprised, no, we don't consider this assisted suicide.

These HMO rules create ethical dilemmas. A California internist had a patient who needed emergency treatment because of fluid buildup in her lungs. Under the rules of the patient's plan, the service would come at a hefty cost. She told the doctor she couldn't have the treatment because she didn't have the money. However, if she was admitted to the hospital, she would have no charges. So the internist bent the rules. He admitted her, and then he immediately discharged her.

Now, I ask you, Mr. Speaker, are HMOs forcing doctors to lie for their patients?

HMOs have pared back benefits to the point of forcing Congress to get into the business of making medical decisions. Take for example the uproar over so-called drive-through deliveries. This cartoon shows that some folks thought health plans were turning their maternity wards into fast food restaurants.

As the woman is handed her new child, the gatekeeper at the drive-through window asks, congratulations, would you like fries with that?

Well, in 1995, Michelle and Steve Bauman testified before the Senate about their daughter, Michelina, who died 2 days after she was born. Their words were powerful and eloquent. Let me quote from Michelle and Steve's statement.

Baby Michelina and her mother "were sent home 2 hours after delivery. This was not enough time for doctors

to discover that Michelina was born with streptococcus, a common and treatable condition. Had she remained in the hospital an additional 24 hours, her symptoms would have surfaced and a professional trained staff would have taken the proper steps so that we could have planned a christening, instead of a funeral.

Her death certificate listed the cause of death as meningitis, said Michelle and Steve, when it should have read "death by the system."

In the face of scathing media criticism and public outrage, health plans insisted that nothing was wrong, that most plans allowed women to stay at least 48 hours, that babies discharged the day of delivery were just as healthy as others.

You know, Mr. Speaker, that line of defense sounds a lot like the man who was sued for causing an auto accident. "Your Honor," he says, "I was not in the car that night, but even if I was, the other guy was speeding and swerved into my lane."

For expectant parents, however, the bottom line was fear and confusion. There is nothing more important to a couple than the health and safety of their child. Because managed care failed to condemn drive-through deliveries, all of us were left to wonder whether our own plans place profits ahead of care.

The drive-through delivery issue is hardly the only example of the managed care industry fighting to derail any consumer protection legislation. What makes this strategy so curious is that most plans had already taken steps to guarantee new moms and infant 2 days in the hospital. Sure, there were some fly-by-nights that might not have measured up, but most responsible plans had already reacted to the issue by guaranteeing longer hospital stays.

The HMO efforts to reassure the public that responsible plans don't force new mothers and babies out of the hospital in less than 24 hours, however, was completely undermined by their opposition to a law ensuring this protection for all Americans. This was a missed opportunity, Mr. Speaker, for the responsible HMOs to get out front, to proactively work for legislation that reflected the way they already operated.

Not only would it have improved managed care's public image, but it would have given them some credibility.

So why then did managed care oppose legislation on this issue? Because the HMO industry is Chicken Little. Every time Congress or the States propose some regulation on this industry, they cry, "The sky is falling; the sky is falling."

I would suggest that by endorsing some common-sense patient protections, managed care would be more believable when they oppose legislation.

Today's managed care market is highly competitive. Strong market ri-

valry can be good for consumers. When one airline cuts fares, others generally match those fares. In health care, when one plan offers improved preventive care or expanded coverage, other market participants may follow suit.

But the competitive nature of the market also poses a danger for consumers. In an effort to bolster profits, plans may deny coverage of care that is medically necessary, or they may gag their doctors to cut costs.

Some health plans have used gag rules to keep their subscribers from getting care that may save their lives.

During congressional hearings 2 years ago, we heard testimony from Allen DeMeurers, who lost his wife, Christy, to breast cancer. They are pictured here with their children. When a specialist at UCLA recommended that Christy undergo bone marrow transplant surgery, her HMO leaned on UCLA to change its medical opinion.

Mr. Speaker, who knows whether Christy would be with her two children today had her HMO not interfered with her doctor-patient relationship?

HMO gag rules have even made their way on to the editorial pages. Here is one such cartoon. A doctor sits across the desk from a patient and remarks, "I will have to check my contract before I answer that question."

Dr. Michael Haugh is a real live example of this problem. He testified before the Committee on Commerce and told how one of his patients was suffering from severe headaches. He asked her HMO to approve a specific diagnostic procedure. They declined to cover it, claiming that magnetic resonance arteriogram was "experimental."

Now, remember, Dr. Peeno testified about the clever ways that health plans decide not to cover requested care.

□ 2015

Dr. Haugh explained the situation in a letter to his patient. In it he wrote: "The alternative to the magnetic resonance arteriogram is to do a test called a cerebral arteriogram, which requires injecting dye into the arteries, and carries a much higher risk to it than the MRA. It is because of this risk that I am writing to tell you that I still consider that an MRA is medically necessary in your case."

Two weeks later the medical director of BlueLines HMO wrote to Dr. Hough. He said, "I consider your letter to the member to be significantly inflammatory. You should be aware that a persistent pattern of pitting the HMO against its member may place your relationship with BlueLines HMO in jeopardy. In the future, I trust you will choose to direct your concerns to my office, rather than in this manner."

This is amazing. The HMO was telling this doctor that he could not express his professional medical judgment to his patient. Cases like these and others demonstrate why Congress needs to pass legislation like the Pa-

tient Right to Know Act, to prevent health plans from censoring exam room discussions.

This gag rule cartoon is even more pointed. Once again, a doctor sits behind a desk talking to a patient. Behind the doctor is an eye chart saying, "Enuf iz enuf." The doctor looks at a piece of paper and tells his patient, "Your best option is cremation, \$359, fully covered." And the patient says, "This is one of those HMO gag rules, isn't it, doctor?"

The HMO industry continues to fight Federal legislation to ban these gag rules. The HMOs and their minions here in Congress still keep the Patient Right to Know Act from coming to the floor, despite the fact that it has 299 cosponsors, Members of Congress, on the bill. The bill is endorsed by more than 300 consumer and health professional organizations and has already been enacted into law for Medicare and Medicaid patients.

Mr. Speaker, I ask the Members, what is wrong with cover all Americans? Even some executives of major managed care plans have privately told me that they are not opposed to the ban on gag rules, because they know that competition can result in a race to the bottom in which basic consumer protections are undermined.

My bill to ban gag rules presents managed care with an opportunity to be on the vanguard of good health care. Instead, they are frittering away another opportunity, just like they did with the drive-through delivery issue. And in opposing a ban on gag rules, HMOs have only fueled bipartisan support for broader and more comprehensive reform legislation.

In recognition of problems in managed care, last September three managed care plans joined with consumer groups to announce their support of an 18-point agenda. Here is a sample of the issues that the groups felt required nationally enforceable standards: guaranteeing access to appropriate services, providing people with a choice of health plans, ensuring the confidentiality of medical records, protecting the continuity of care, providing consumers with relevant information, covering emergency care, disclosing loss ratios, banning gag rules.

These health plans and consumer groups wrote, "Together we are seeking to address problems that have led to a decline in consumer confidence and trust in health plans. We believe that thoughtfully designed health plan standards will help to restore confidence and ensure needed protection."

Mr. Speaker, I could not have said it better myself. These plans, including Kaiser Permanente, HIP, and Group Health of Puget Sound, probably already provide patients with these safeguards. So it would not be a big challenge for them to comply with nationally enforceable standards. By advocating national standards, these HMOs distinguish themselves in the market as being truly concerned with the health of their enrollees.

Noting that they already make extensive efforts to improve their quality of care, the chief executive officer of Health Insurance Plan, known as HIP, said, "Nevertheless, we intend to insist on even higher standards of behavior within our industry, and we are more than willing to see laws enacted to ensure that." Let me repeat that: "We are more than willing to see laws enacted to ensure that result."

One of the most important pieces of their 18-point agenda is a requirement that plans use a layperson's definition of an emergency. Too often, health plans have refused to pay for care that was delivered in an emergency room.

The American Heart Association tells us that if we have crushing chest pain, we should promptly go to the emergency room, because that could be a warning of a possible heart attack. But sometimes HMOs refuse to pay if the tests later on are normal. Mr. Speaker, if the HMO only pays when the tests are positive, I guarantee that people will delay getting proper treatment for fear of them getting a big bill. They could die if they delay diagnosis and treatment.

Another excuse HMOs use to deny payment for ER care is the patient's failure to get preauthorization. This cartoon vividly makes the point: "Kuddlycare HMO. My name is Bambi. How may I help you? You are at the emergency room and your husband needs an approval for treatment? Gasping? Writhing? Eyes rolled back in his head? Doesn't sound all that serious to me. Clutching his throat? Turning purple? Uh-hmm. Have you tried an inhaler? He's dead? Well, then he certainly doesn't need treatment, does he?" And then the reviewer puts down the phone and says, "People are always trying to rip us off."

Does this cartoon seem too harsh? Ask Jacqueline Lee. In the summer of 1996 she was hiking in the Shenandoah Mountains when she fell off a 40-foot cliff. She fractured her skull, her arm, her pelvis. She was airlifted to a local hospital and treated. Now, Members will not believe this. Her HMO refused to pay for the services because she failed to get "preauthorization." I ask the Members, what was she supposed to do, lying at the bottom of the 40-foot cliff with broken bones? Call her HMO for preauthorization?

I am sad to say that, despite strong public support to correct problems like these, managed care regulation still seems stalled here in Washington. Some opponents of legislation insist that health insurance regulation, if there is to be any at all, should be done by the States. Other critics worship at the altar of the free market and insist that it is "the invisible hand" that cures the ills of managed care.

I am a strong support of the free market, and I wish we could rely on ADAM SMITH's invisible hand to steer plans into offering the services that consumers want.

While historically State insurance commissions have done an excellent

job of monitoring the performance of health plans, Federal law puts most HMOs beyond the reach of State regulation. Let me repeat that. Most people do not know this. Federal law puts most HMOs beyond the reach of State regulation.

So we ask, how is that possible?

More than 2 decades ago Congress passed the Employee Retirement Income Security Act, which I will refer to as ERISA, in order to provide some uniformity for pension plans in dealing with different State laws. Health plans were included in ERISA almost as an afterthought, and the result has been a gaping regulatory loophole for self-insured plans under ERISA.

Even more alarming is the fact that this lack of effective regulation is coupled with an immunity from liability for negligent actions. Let me repeat that: This lack of effective regulation is coupled with an immunity from liability for negligent actions. If the HMO has made a negligent action which has resulted in harm or death of a patient and they are under the ERISA exemption, they are scot-free of any liability.

Mr. Speaker, personal responsibility has been a watchword for this Republican Congress. This issue is no different. I have worked with the gentleman from Georgia (Mr. CHARLIE NORWOOD) and others to pass legislation that would make health plans responsible for their conduct. Health plans that recklessly deny needed medical service should be made to answer for their conduct. Laws that shield them from their responsibility only encourage HMOs to cut corners.

Take this cartoon, for example. With no threat of a suit for medical malpractice, an HMO beancounter stands elbow to elbow with the surgeon in the operating room.

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When the doctor calls for a scalpel, the bean counter says "pocket knife." The doctor asks for suture, bean counter says "Band-Aid." The doctor says "Let's get him into intensive care." HMO bean counter says, "Call a cab."

Mr. Speaker, some States have responded. Texas, for instance, has responded to HMO abuses by passing legislation that would make ERISA plans accountable for improper denials of care. But that law, Mr. Speaker, is being challenged in court and a Federal standard is needed to protect all consumers.

The lack of legal redress for an ERISA plan's medical malpractice is hardly its only shortcoming. Let me describe a few of ERISA's other weaknesses: ERISA does not impose any quality assurance standards or other standards for utilization review. Except as provided for in Kassebaum-Kennedy, ERISA does not prevent plans from changing, reducing or terminating benefits.

With few exceptions ERISA does not regulate a plan's design or content,

such as covered services or cost sharing. ERISA does not specify any requirements for maintaining plan solvency. ERISA does not provide safeguards of a State Insurance Commissioner.

It seems to me that we can take one of three approaches to reforming the way health plans are regulated by ERISA. The first would be to do nothing. But, Mr. Speaker, I have demonstrated why I think, and I think most of my colleagues would agree, that is not acceptable.

The second option would be to ask the States to re-assume the responsibility of regulating these plans. This was the traditional role of States and they continue to supervise other parts of the health insurance market. But I will tell why that will not work. Turning regulation of ERISA plans over to States will be fought tooth and nail by big business and by HMOs and it will not happen.

That only leaves one viable option: some minimal, reasonable, Federal consumer health protections for patients enrolled in ERISA plans.

There are many proposals on the table, including the Patient Access to Responsible Care Act, the Patient Bill of Rights, the 18-point agenda released by Kaiser H.I.P. and AARP. Whether we enact one of these options or some other yet to be drafted, Congress created the ERISA loophole and Congress should fix that loophole.

Defenders of the status quo sometimes say that making plans subject to increased State or Federal regulation is not the answer. They insist that like any other consumer good, managed care will respond to the demands of the market. I would note, Mr. Speaker, that I know of no other industry that is not liable for their acts of misconduct like self-insured ERISA health plans. So the shield from liability provided by ERISA by itself distorts the health care market.

It differs from a traditional market in other ways as well. For example, the person consuming health care is generally not paying for it. Most Americans get their health care through their employer. Because the primary customer, the one paying the bills, is the employer, the HMOs have to satisfy their needs before they satisfy the needs of the patients. And the employer's focus on the cost of the plan may draw the HMO's attention away from the employee's desire for a decent health plan.

As Stan Evans noted in "Human Events," many HMOs operate on a capitated basis. This means that plans are paid a flat monthly fee for taking care of you. This translates to the less they spend on medical services, the more profit they make. How many markets, Mr. Speaker, function on the premise of succeeding by giving customers less of what they want?

Take a look at this cartoon which illustrates perfectly the bottom-line mentality of HMO plans. The patient is

in traction while the doctor reviews his chart. The HMO bedside manner, the doctor says, "After consulting my colleagues in Accounting, we have concluded you are well enough. Now go home."

Are HMOs paying attention to their patients' health or to their stockholders' portfolios?

Stan Evans again hit the nail on the head when he noted "Paid a fixed amount of money per patient regardless of the care delivered, HMOs have a powerful motive to deliver a minimum of treatment. Care denial, pushing people out of hospitals as fast as possible, blocking access to specialists and the like are not mistakes or aberration. They stem directly from the nature of the setup in which HMOs make more money by delivering less care, thus pitting the financial interest of the provider against the medical interest of the patient."

His comment raises an important issue. Presented with tragedies like those of the Baumans or Mrs. DeMeurers, managed care defenders argue that "those people are just anecdotes."

What Mr. Evans points out is that cases like these are not mistakes or aberrations or "anecdotes." They are exactly the outcomes we would expect in a system that rewards those who undertreat patients.

Finally, Mr. Speaker, markets only function when consumers have real choices. Dissatisfied consumers have limited options. Most employers offer employees very few health plans. For many, the choice of health plans is simple: "Take it or leave it."

Freedom in the health insurance market for many now means quitting your job if you do not like your HMO. There is not a free market when consumers cannot switch to a different plan. But even if we were to put aside all of these arguments and assume that health insurance was a free market, there is still the need for legislation to guard patients from abuses. The notion of consumer protections is consistent and supportive of our concept of free markets.

In his book, "Everything For Sale," Robert Kuttner points out the problems of imperfect markets. "Industries such as telecommunications, electric power and health care retain public purposes that free-market forces cannot achieve. For example, as a society we remain committed to universal access to certain goods. Left to its own device, the free market might decide that delivering electricity and phone service to rural areas and poor city neighborhoods is not profitable, just as the private market brands cancer patients as 'uninsurable.'"

Think for a minute, Mr. Speaker, about buying a car. Federal laws ensure that cars have horns and brakes, headlights. Yet despite these minimum standards we do not have a "nationalized auto industry." Instead, consumers have lots of choices. But they know

that whatever car they buy will meet certain minimum safety standards. You do not buy safety "a la carte."

The same notion of basic protections and standards should apply to health plans. Consumer protections will not lead to socialized medicine any more than requiring seat belts has led to a nationalized auto industry. In a free market, these minimum standards set a level playing field that allows competition to flourish.

Critics of regulating managed care also complain that new regulation will drive up the cost of health insurance. How often have I heard this argument. In criticizing the Patient Access to Responsible Care Act they cite a study showing that certain provisions could increase health insurance premiums from 3 to 90 percent. Three to 90 percent. What a joke. Such a wide range is meaningless. It must be an accountant's way of saying, "I don't know."

Other studies have said that costs may go up slightly but nothing near the doomsday figures suggested by opponents of this legislation. A study by the accounting firm Muse & Associates shows that premiums will increase between seven-tenths of 1 percent and 2.6 percent if the Patient Access to Responsible Care Act is enacted.

And do not let the HMOs tell anyone that the rising premiums we are seeing this year are the result of Federal regulation. HMOs have been charging below-cost premiums for years, and as a result we are now seeing premium increases long before the passage of any Federal consumer protection legislation.

Keep in mind also the shareholder's philosophy of making money can come into conflict with the patient's philosophy of wanting good medical care. To save money many plans have nonphysician reviewers to determine if callers requesting approval for care really need it. Using medical care "cookbooks," they walk patients through their symptoms and then reach a medical conclusion.

Unfortunately, the cookbooks do not have a recipe for every circumstance, like the woman who called to complain about pain caused by the cast on her wrist. The telephone triage worker asked the woman to press down on her fingernail and see how long it took for the color to return. Unfortunately, over the phone she could not see that the patient had fingernail paint.

How far can this go? Well, like this cartoon shows, pretty soon we could all be logging on to the Internet and using the mouse as a stethoscope.

This trend should trouble every one of us. Medicine is part science, it is part art. Computer operators cannot consider the subtleties of a patient's condition. Sometimes answers can be known by reading a chart. But sometimes doctors reach their judgments by a sixth sense that this patient is really sick. There are certain things that computers cannot comprehend.

Mr. Speaker, doctors are expected to be professional, to adhere to standards

and to undergo peer review. Most of all, they are expected to be their patients' advocates, not to be government or insurance apologists. It is in the interest of our citizens that their doctor fights for them and not be the "company doc."

Like a majority of my colleagues, I am a cosponsor of H.R. 1415, the Patient Access to Responsible Care Act, otherwise known as PARCA. In an effort to derail this legislation, the managed care community has made a number of false statements about this bill. For example, they repeatedly state that PARCA would force health plans to contract with any provider who wanted to join its network. That is clearly a false statement.

In two separate places the bill states that it should not be considered an "any willing provider" bill. PARCA simply includes a provider nondiscrimination provision similar to what was enacted in Medicare last year. Provider nondiscrimination and "any willing provider" are no more the same than equal opportunity and affirmative action.

Mr. Speaker, similarly, some opponents have suggested that the bill would force health insurance to be offered on a guaranteed issue or a community rating basis, and I say this is a nonissue. The gentleman from Georgia (Mr. NORWOOD) and I oppose community rating and guaranteed issue, and will not support any bill that would result in community rating or guaranteed issue.

Mr. Speaker, when I began these remarks I mentioned the focus group held in Maryland by Frank Luntz. At end of the session he described a package of consumer protections much like the Patient Access to Responsible Care Act and he asked participants whether they were in favor. All 28 hands shot up. One woman even said she was shocked that it did not already exist.

Next Mr. Luntz asked how many would support the package if it caused health insurance premiums to increase 5 percent. All 28 thought that was a reasonable price to pay for those protections. In fact, 27 out of 28 would support the proposal even if it caused insurance premiums to increase by 10 percent, and nearly three-quarters still supported the package if it caused insurance premiums to increase by 15 percent. Yet, as I mentioned, Mr. Speaker, a study by Muse & Associates shows that enactment of PARCA would only raise premiums between seven-tenths of 1 percent and 2.6 percent.

Mr. Speaker, consumers have lost confidence in their HMOs. The public clearly thinks that they have cut costs at the expense of quality. It is time for reform. The American public is crying for help and is looking to Congress for answers. The time for talking has passed. Our goal should be passage of comprehensive patient protection legislation.

Mr. Speaker, I am committed to seeing legislation enacted by the close of

this 105th Congress, and I am open to working with all interested Members, Democrat or Republican, to develop a bipartisan patient protection bill. In the meantime, Mr. Speaker, H.R. 586, the Patient's Right to Know Act, which has 299 cosponsors and would ban gag rules, should be brought to the floor for a vote.

□ 2045

Mr. Speaker, just last week a pediatrician told me about a 6-year-old child who had nearly drowned. The child was brought to the hospital and placed on a ventilator. The child's condition was serious. It did not appear that he would survive. As the doctors and the family prayed for signs that the boy would live, the hospital got a call from the boy's insurance company. Explained the HMO, "Home ventilation is cheaper than inpatient care. I was wondering if you had thought about sending the boy home."

Or consider the death of Joyce Ching, a 35-year-old mother from Fremont, California. Mrs. Ching waited nearly 3 months for an HMO referral to a specialist, despite continued rectal bleeding and severe pain. Joyce Ching was 35 years old when she died from a delay in diagnosis of her colon cancer. Joyce Ching, Christy DeMeurers, Michelina Baumann, Dr. Peeno's patient, Mr. Speaker, these are not just "anecdotes." These are real people who are victims of HMOs. Let us fix the problem. The people we serve are demanding it.

To paraphrase Shakespeare: Hath not these "anecdotes," these HMO victims' eyes? Hath not these "anecdotes" hands, organs, dimensions, senses, affections, passions, fed with the same food, hurt with the same weapons, subject to the same diseases, warmed and cooled by the same winter and summer as these same HMO apologists? If you prick the "anecdotes," do they not bleed? If you tickle these "anecdotes," do they not laugh? If you shortcut their care for profits, do they not die? And for those who dismiss them as "anecdotes," will they not revenge?

Mr. Speaker, let us act now to pass meaningful patient protections. Lives are in the balance.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2400, BUILDING EFFICIENT SURFACE TRANSPORTATION AND EQUITY ACT OF 1997

Mr. MCINNIS, from the Committee on Rules, submitted a privileged report

(Rept. No. 105-476) on the resolution (H. Res. 405) providing for consideration of the bill (H.R. 2400) to authorize funds for Federal-aid highways, highway safety programs, and transit programs, and for other purposes, which was referred to the House Calendar and ordered to be printed.

MAKING IN ORDER ON WEDNESDAY, APRIL 1, 1998, MOTION TO SUSPEND THE RULES AND PASS H.R. 1151, CREDIT UNION MEMBERSHIP ACCESS ACT

Mr. MCINNIS. Mr. Speaker, I ask unanimous consent that, notwithstanding clause 1 of rule XXVII, it be in order at any time on Wednesday, April 1st, 1998, for the Speaker to entertain a motion to suspend the rules and pass the bill, H.R. 1151, Credit Union Membership Access Act.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Colorado?

There was no objection.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. GREENWOOD (at the request of Mr. ARMEY) for after 5:00 p.m. today on account of official business.

SPECIAL ORDERS GRANTED

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

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

Mr. MASCARA, for 5 minutes, today.

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

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

Ms. BROWN of Florida, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

(The following Member (at the request of Mr. DOOLITTLE) to revise and extend his remarks and include extraneous material:)

Mr. HOEKSTRA, for 5 minutes each day, today and on April 1st.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. SAXTON for 5 minutes today.

(The following Member (at her own request) to revise and extend her re-

marks and include extraneous material:)

Mrs. KENNELLY of Connecticut, for 5 minutes, today.

EXTENSION OF REMARKS

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

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

Mr. KIND.

Mr. MCDERMOTT.

Mr. STARK.

Mr. FILNER.

Mr. CRAMER.

Mr. BENTSEN.

Mr. LAFALCE.

Mr. ALLEN.

Mr. MOAKLEY.

Mr. VENTO.

Mr. KANJORSKI.

Mr. SCHUMER.

Mr. WYNN.

Mr. RUSH.

Mr. SABO.

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

Mrs. ROUKEMA.

Mr. GILMAN.

Mr. REDMOND.

Mr. WOLF.

Mr. SOLOMON.

Mr. GEKAS.

Mr. KLUG.

SENATE BILL REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 1751. An act to extend the deadline for submission of a report by the Commission to Assess the Organization of the Federal Government to Combat the Proliferation of Weapons of Mass Destruction; to the Committee on International Relations, and in addition, to the Permanent Select Committee on Intelligence, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 8 o'clock and 50 minutes p.m.) the House adjourned until Wednesday, April 1, 1998, at 10 a.m.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports and amended reports concerning the foreign currencies and U.S. dollars utilized for official foreign travel during the second quarter of 1997 and the first quarter of 1998 by various Committees of the House of Representatives, pursuant to Public Law 95-384, as well as consolidated report of foreign currencies and U.S. dollars utilized for Speaker-authorized official travel in the first quarter of 1998 are as follows: