there, not until the dictators are gone and the teachers of freedom have erected a new Lady Liberty, our gift to the students, the students of freedom.

I was in school when President Reagan, standing in front of the Berlin Wall said, ''Mr. Gorbachev, take down this wall.''

Many saw the scene as a reckless, silly old man standing against the night calling for the light and truth of freedom. But President Reagan was sure of what he spoke. He stood for freedom. He stood for principle, and he dared to dream of a different and better world.

How can it be that we have shifted so quickly to a place of compromise and appeasement, to a place of favoring corporate profit over foundational principles, to a place of investigating the nearly unutterable, that campaign contributions may have driven the transfer of American-made missile guidance systems to an enemy of freedom?

Last week the House voted 409 to 10 to set up a special nine-member committee with far-reaching authority to look into whether U.S. national security has been undermined in this matter. According to our intelligence agencies, at least 13 intercontinental ballistic missiles with American missile guidance systems may be pointed at the United States of America.

''Knock it down,'' the dictators ordered. God forbid that it should happen to the real Lady of Liberty. God forbid.

REPORT ON H.R. 4112, LEGISLATIVE BRANCH APPROPRIATIONS ACT, 1999

Mr. KINGSTON, (during the special order of Mr. NEUMANN) from the Committee on Appropriations, submitted a privileged report (Rept. No. 105–595) on the bill (H.R. 4112) making appropriations for the Legislative Branch for the fiscal year ending September 30, 1999, and for other purposes, which was referred to the Union Calendar and ordered to be printed.

The SPEAKER pro tempore (Mr. DIAZ-BALART). Pursuant to clause 8 of rule XXI, all points of order are reserved on the bill.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4103, DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 1999

Mr. MCINNIS (during the special order of Mr. PALLONE), from the Committee on Rules, submitted a privileged report (Rept. No. 105–596) on the resolution (H. Res. 484) providing for consideration of the bill (H.R. 4103) making appropriations for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 4104, TREASURY, POSTAL APPROPRIATIONS ACT, 1999

Mr. MCINNIS (during the special order of Mr. PALLONE), from the Committee on Rules, submitted a privileged report (Rept. No. 105–597) on the resolution (H. Res. 485) providing for consideration of the bill (H.R. 4104) making appropriations for the Treasury Department, the United States Postal Service, the Executive Office of the President, and certain Independent Agencies, for the fiscal year ending September 30, 1999, and for other purposes, which was referred to the House Calendar and ordered to be printed.

MANAGED CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, tonight I would like to talk again about the issue of managed care reform, and I have said before on the floor that this issue, without question, has become one of the most important on the minds of Americans, not only in my district but I think throughout the country.

The reason that it has become so important is because patients are being abused within managed care organizations. Patients often lack basic elementary protections from abuse, and these abuses are occurring because insurance companies and not doctors are dictating which patients can get what services under what circumstances.

Within managed care organizations or HMOs, the judgment of doctors is increasingly taking a back seat to the judgment of insurance companies. Medical necessity is being shunted aside by the desire of bureaucrats to make an extra buck, and people are literally dying because they are not getting the medical attention they need and, ironically enough, are in theory paying for through their premiums.

This is not an exaggeration. Myself and the gentleman from Iowa (Dr. GANSKE), who will be joining me tonight, and other colleagues on both sides of the aisle have told numerous stories about people throughout the country who have been negatively impacted by managed care.

As I mentioned before, because of the importance of this issue, there are a number of legislative proposals that have been introduced to give patients the protections they deserve from managed care organizations. And working with the Democratic Caucus' Health Care Task Force, which I co-chair, the gentleman from Michigan (Mr. DINGELL) introduced legislation which would provide patients with a comprehensive set of protections from managed care abuses.

His bill, the Patients Bill of Rights, is not an attempt to destroy managed care. It is an attempt to make it better. To emphasize that point, supporters of managed care reform want just that, reform, not a dismantling of managed care.

The Patients Bill of Rights would help bring about that reform by putting medical decisions back where they belong, with doctors and their patients. I have to mention that this is also a bipartisan bill, with 7 Republican cosponsors, including my colleague the gentleman from Iowa (Dr. GANSKE).

Unfortunately, though, the Patients Bill of Rights does not enjoy the support of the Republican leadership. It is not clear exactly where they stand on the issue of managed care reform. There is still a task force that the Republicans have put together and has been meeting, but so far the Republican leadership has not allowed any managed care reform bill to be heard in committee or to be marked up in committee or to come to the floor, and I believe that that is because of the power of the insurance industry that that has not happened so far.

Mr. Speaker, tonight I just wanted to say that there have been some recent important developments on this issue. I am going to let my colleague, the gentleman from Iowa (Dr. GANSKE) go into some of this, but I just wanted to say that legislation was introduced today by the gentleman from Iowa (Dr. GANSKE) and the gentleman from Michigan (Mr. DINGELL), again on a bipartisan basis, to try to bring the Patients Bill of Rights and possibly other managed care reform to the floor through what we call a discharge petition. Basically a discharge petition is necessary when the House leadership will not allow a bill to come to the floor through the normal committee process.

I just wanted to say how much I appreciate the efforts of my colleague from Iowa, not only in introducing this discharge petition today with the gentleman from Michigan (Mr. DINGELL) but also because the gentleman from Iowa (Dr. GANSKE) has been an outspoken champion and leader of the movement here in the House to bring the Patients Bill of Rights to the floor, and I think he deserves a tremendous amount of credit for that reason.

The only thing I also wanted to mention today about this discharge petition is that I believe that there is a tremendous amount of support for this. As my colleague knows well, we have been working closely with over 150 groups that support the Patients Bill of Rights. I think the Patients Bill of Rights now has 192 cosponsors.

Another bill on managed care reform which the gentleman from Iowa (Dr. GANSKE) has supported, the PARCA bill, has even more cosponsors, from what I understand, so I do not think it is going to be difficult to get support for this discharge petition.

The last thing that I did want to mention though, before yielding to the

gentleman, is that we are going to push for this discharge petition over this week and during the congressional recess so that when we come back, we hopefully will get enough signatures so that we can bring the Patients Bill of Rights to the floor.

I am still very concerned that the Republican leadership is going to try to produce a watered-down managed care reform bill. As we know, the Speaker has already rejected one proposal by the GOP task force because it had too many patient protections in it. There are reports now that some patient protections have crept back into the GOP plan and that the task force will come forward with a bill this week or sometime in the future. But I think we need to watch out that it is not legislation that is substantially weaker than the Patients Bill of Rights or the PARCA bill or some of the other strong legislation that we have been pushing. Obviously, we are going to keep a careful eye on that as we proceed over the next few weeks.

With that. Mr. Speaker, I yield to the gentleman from Iowa (Dr. GANSKE).

Mr. GANSKE. Mr. Speaker, I appreciate the remarks of my colleague from New Jersey. Once again, here we are on the floor addressing our colleagues about abuses in managed care as they relate to a Federal law that was passed some 25 years ago called ERISA, Employee Retirement Income Security Act, which basically gave legal immunity to health plans that are health plans for self-insured employer plans.

I think without that prior Federal legislation, we would not need to be here tonight. But because the majority of people who get their insurance from their employer are now in HMOs versus the traditional type of indemnity insurance, and because so few of them have a true choice in terms of the health plan that they choose, many employers now will only offer an employee one plan, take it or leave it, so that if you are talking about choice in the health care marketplace, you are really talking about having to change your job before you have a choice.

I do want to address the issue of the resolution that I introduced today along with Mr. DINGELL. Nothing would please me more than to hear my Republican leadership say before August recess we are going to have a full and fair debate on the floor on managed care. After all, we have two bills, the Patients Bill of Rights, Patient Access to Responsible Care Act, with broad bipartisan support. I think it is well recognized that if there is debate on the floor, one of these bills could easily pass with much more than a majority.

□ 1945

There is significant sentiment in the Republican Conference for a patient protection legislation. So it would please me greatly if my own Republican leadership would come out and say, do you know what, we agree with 9 out of 10 Americans that we should pass Federal legislation with federally enforceable standards for quality protection.

We are going to bring this to the floor in a fair manner, not with the type of rule that we have seen with campaign finance reform, which is death by 1,000 amendments, but a fair rule giving both sides of the issue a chance to debate this issue on the floor, to talk about the abuses in the industry, how to fix them, how to provide protections for the average American similar to the type of protections that we have already passed for Medicare patients and the balanced budget act. We will go into that in a little bit more detail.

So nothing would please me more than to have the leadership not make a discharge petition a necessity. Unfortunately, we have seen over the last 3 months, one delay after another from the Republican Health Care Task Force.

We are told that tomorrow we will hear about some principles of legislation coming out of the task force, but we are also told that a bill is not available to look at. In fact, there may not be a bill available until after the Fourth of July recess.

As everybody knows, we are looking at a shortened legislative session. And I think it is fair to say from conferences I have had with my colleagues that there are some Members of the House and of the Senate that want to delay this legislation and delay it and delay it; delay it until we get into October, and then all of a sudden, gee whiz, we have to adjourn so we can go home and campaign for the fall elections. It is just too bad that we did not get to this issue.

I do not think that that is the right way to go, and so I am looking forward to the Republican leadership responding to the majority of the House bringing this forward for a full debate in a fair way with a fair rule, time-limited fashion, prior to August recess. If that is the case, there will not be any need for a discharge petition.

But I would just like to talk a little bit, before yielding back to my colleague, about why we need this legislation. We could come here to the floor every night, and we could give case after case of an abuse in the managed care in the industry. But I want to just read one story written by the patient about how he was treated by his HMO.

This is related by a fellow by the name of Edward Mycek, and these are his words:

> In November of 1997, I found out that I had prostate cancer. After discussing treatment and recovery options, my doctor advocated surgery to remove the prostate. I decided to get another opinion.
>
> After consulting with the new doctor at Loma Linda University Medical Center, I decided on proton and 3–D conformational radiation treatment. The new physician and his staff concluded that I was an excellent candidate for the treatment for a number of reasons.
>
> The doctors at Loma Linda Medical Center then contacted my insurer, which said that it would pay for the full treatments. In fact, my insurer called back to inform me that the insurance policy covered these treatments, and they would notify the medical center that the procedure had been authorized. The authorization never arrived at the medical center.

So, Mr. Mycek continues:

> Worried about the delay of my care, I called my insurer, who told me that they had reversed the decision. The company claimed that this treatment, this radiation treatment was 'experimental and investigational.' Loma Linda, then faxed factual information to my insurer which explained that the procedure was not experimental or investigational.

In fact, I as a physician have known about this treatment for a long time. It is a commonly accepted type of treatment for prostate cancer.

The medical center doctor also wrote a letter that discussed the differential recovery rates. The radiation had a recovery rate of 98 percent versus 83 percent for surgery.

Mr. Mycek continues:

> After several stressful weeks, I was still denied hope. I asked my insurer what other treatments were covered. They responded by saying they could not say. After being passed back and forth like a ping-pong ball, I could not wait any longer.
>
> On February 17, 1998, after paying up front himself, I began my first of 44 radiation treatments. This is a financial burden on our family. Today I have completed all 44 radiation treatments, and I am due for a check-up.
>
> After all is said and done, Mr. Mycek continues, I still feel that I have been denied needed care by an agent 3,000 miles away, seated at a desk and appointed by the company to decide the quality of care I receive. I have worked for this well-known company for almost 32 years, and this was the first major claim I ever made.
>
> Because my insurer is protected by ERISA, I can recover no damages from them. I do not have the resources to pressure my insurer to provide better care. Is this ERISA law a fair and just medical insurance law to employees,

Mr. Mycek continues. Not by any means.

Well, this is just one example of thousands that we could bring to the floor to discuss why we need to have legislation like this.

I keep hearing from my colleagues, my conservative Republican colleagues, and I should point out that I have one of the more conservative voting records in the House, that, gee whiz, you know, this organization could interfere with free markets.

I would just like to point out an article that appeared in the June 26 issue of Human Events. Human Events is one of the more conservative newspapers in publication. It is published by Eagle Forum. One of the more conservative columnists is a fellow by the name of M. Stanton Evans.

Mr. Evans wrote this article: HMO Rationing Threatens Patients: Why and How Conservatives Should Support PARCA Reform.

Mr. Evans says,

> Once seen as a magic cure for rising health costs, managed care has become a serious problem in its own right.

Remember, this is a very conserv-

ative columnist for one of the most conservative weeklies in the country.

He continues:

Reports of care denial, quicker and sicker release of patients, charges of wrongful death, and suffering are now familiar items. But lobbyists for business, free market think tanks, editorialists with leverage on the GOP, have charged forth defending HMOs from this type of legislation, arguing that a crackdown on managed care would be an intolerable interference with 'the market.'

Mr. Stanton continues:

However, as previously noted in this column, such arguments are totally off base. HMOs and managed care are not free market in any serious meaning of the term. It is worth repeating the neglected point that HMOs resemble in their basic structure the so-called global budgets of collectivist systems overseas in which a certain fixed amount of money is allocated to pay for everyone's free care. And doctors get the dirty job of denying treatment. They do things this way abroad because there is no market.

Then Mr. Stanton Evans continues:

The bottom line of this repressive sequence is that HMOs are rationing machines in a government-spawned nonmarket setting, which means the market plea of protecting them from PARCA or a patient bill of rights fizzles.

Finally, Mr. Stanton Evans continues, and he summarizes:

A more sensible position on the topic might look approximately as follows: First, so long as HMOs are called on to ration care in a nonmarket framework, PARCA or something like it should be adopted and amended so as to distinguish between legitimate indemnity insurance on the one hand and top-down health care denial on the other.

I would just like to point out this is a very conservative publication. There is broad bipartisan support across the ideologic spectrum for a patient bill of rights type of legislation. This is something that we ought to move forward on and pass and at least have a debate on the floor of Congress on this issue.

Mr. PALLONE. Mr. Speaker, I appreciate the gentleman's remarks, and I think that there is no question that these patient protections are needed. We will get into more of them.

Mr. Speaker, I would just like to continue along the line of what the gentleman from Iowa (Mr. GANSKE) mentioned. We said over and over again the type of patient protections that we are seeking either with the patient's bill of rights legislation or the PARCA bill is really nothing more than a commonsense approach, the type of protections that I think most Americans would think that they already have with their health plan or with their health insurance but, unfortunately, they do not.

I just wanted to get into two provisions of the patient's bill of rights and give two examples again similar to what the gentleman from Iowa (Mr. GANSKE) did. One is the important access, if you will, to specialty care. The bill, the patient's bill of rights, establishes certain standards to ensure hassle-free access to appropriate specialty care.

What it says basically is that plans must have a process for individuals to access specialty care if they need it. If the plan does not have an appropriate specialist in the network, it must provide an outside referral to such a specialist, at no additional cost to the patient.

I had an example. There is a group called Consumers for Quality Care that actually put out what they call ''Casualty of the Day.'' Every week, they put out some examples of patients who suffered casualties from abuse by HMOs.

This one I think applies very well to this issue of specialty care or lack of access provided by the HMO or the managed care organization to specialty care. If I could just use it as an example. This is Judith Packevicz from Saratoga Springs, New York. Actually, that is a different example I want to give for another one. I apologize.

The example I want to give with regard to the specialty care is Francesca Tenconi, who is an 11-year-old girl from Oakland, California. Again, this is from Consumers for Quality Care. She suffers from, and the gentleman from Iowa (Mr. GANSKE) probably will be able to help me with this better, pemphigus foliaceous.

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

Mr. PALLONE. I yield to the gentleman from Iowa.

Mr. GANSKE. I believe it is pemphigus foliaceous.

Mr. PALLONE. I am not pronouncing it, but I thank the gentleman for the help. This is an autoimmune disease in which the body's immune system becomes overactive and attacks the protein which adheres to the top layer of skin to the body.

Her parents had to battle with their HMO to insist upon appropriate diagnosis and medical care. According to Donald Tenconi, Francesca's father, her medical insurance ordeal began in December 1995 when, at the age of 11, she developed what was diagnosed as a skin rash.

By March, the condition had spread and become worse. By late April, the condition was so bad she could not attend school. During this period, several requests were made for referrals to specialists outside the HMO, and these were all denied.

Finally, on May 8, 1996, almost 6 months after the first appearance of symptoms, the HMO sent biopsies to out-of-network doctors and finally obtained an accurate diagnosis. The diagnosis was the disease that I mentioned and that the gentleman from Iowa (Mr. GANSKE) translated for me.

Even after receiving the diagnosis, the Tenconis' HMO still insisted on treating the disease primarily with its own doctors, in-network doctors. It was not until February of 1997, over 1 year after the symptoms first appeared, that the HMO finally agreed to allow Francesca to receive care at Stanford Medical Center, which possessed the doctors capable of providing the best care available in the San Francisco Bay area.

Explaining the prolonged and unnecessary pain of lying down without skin on your back for over 1 year, Donald said, this is her father again, ''If you feel this pain, you will shed tears of pain, the same pain that Francesca shed night after night, week after week for many months.''

Again, I mention it because I think that it is necessary to have the patient protection that provides access to specialty care outside the network when the in-network doctors do not have the ability to take care of the individual.

□ 2000

Under the Patients' Bill of Rights, not only is that the case that they have to allow you to go outside of the network if there is not someone inside who has that specialty ability, but also patients with serious ongoing medical conditions are able to choose a specialist to coordinate their primary and specialty care. So if you have a chronic illness that requires this kind of specialty care over a long period of time, essentially your specialist becomes something like your primary care provider so you do not have to constantly go back and get these referrals.

The other example I wanted to mention, again one of the other major protections that we talk about is that decisions about provision of medical care should be based on what is medically appropriate for the patient. They should not be based on the cost considerations of an accountant or bureaucrat. The Patients' Bill of Rights prohibits health plans from arbitrarily overriding medical decisions by your physicians when these decisions are made according to generally accepted principles of medical practice. Again that refers to length of stay in the hospital, equipment, a particular type of surgery that may be required, that this is supposed to be done based on what is medically appropriate based on the decision of your doctor rather than the bureaucrats.

Again, I think the gentleman from Iowa mentioned the other day an example of somebody who needed a liver transplant. I do not know if this is exactly the same example, but I would just like to mention it again if I could. This is the case I mentioned before, Judith Packevicz from Saratoga Springs, who suffered from a rare form of cancer of the liver. The HMO refused to pay for a liver transplant which was recommended by her oncologist with the support of all her treating physicians. Again, a decision that was made based on what the doctors felt was appropriate under the circumstances to have this liver transplant, but because it cost an estimated $345,000, the HMO, of course, refused to have it done and did not really give an explanation about why. I will say here it was undoubtedly the cost of it. Again they made a decision to deny her this liver transplant

even though her son, Thomas Dwyer, was a willing and able donor. There were 13 other friends of Judith who volunteered to donate a part of their liver. So she had somebody willing, able, would not do it because of the cost undoubtedly, and she actually had to bring suit, again under ERISA. She cannot recover damages, only the cost of the procedure that was denied in the first place, and although it is possible that she ultimately would get the liver transplant, there was no way for her really to sue for any damages that would result because of the issue that you brought again which is that the HMO basically cannot be sued for damages.

Mr. GANSKE. If my colleague would yield, for the reasons that we have outlined tonight and in previous special orders, there is broad support by a number of organizations for this. I have eight pages here in fine type of endorsing organizations for both the Patients' Bill of Rights and the Patient Access for Responsible Care Act. With your indulgence, I will just read through a few of these. These are all organizations that have endorsed this type of legislation:

The Alzheimer's Association, the American Academy of Child Psychiatry, the American Academy of Emergency Medicine, the American Academy of Pediatrics, the American Association of Respiratory Care, the American Association of Nurse Anesthetists, the American Association of Pastoral Counselors. I am obviously not hitting all of these organizations on this list, just selecting a few, so for those that I do not mention, forgive me.

The American Association of Retired Persons, AARP, the American Association of Mental Retardation, the American Cancer Society, the American Dental Association, the AFL-CIO, the American Federation of Teachers, the American Heart Association, the American Lung Association, the American Medical Association, the American Nurses Associations, the American Public Health Association, Catholic Charities, Children's Defense Fund, Consumer Federation of America, Consumers Union, Families USA, even companies like Genzyme, League of Women Voters, Meals on Wheels of Lexington, National Association of Rural Mental Health, National Association of Children's Hospitals, National Association of Public Hospitals, National Consumers League, National Council of Senior Citizens, National Multiple Sclerosis Society. These are all organizations. Let me continue.

NETWORK: A National Catholic Social Justice Lobby; Service Employees International Union, United Cerebral Palsy. Mr. Speaker, I submit these lists for the CONGRESSIONAL RECORD, as follows:

ORGANIZATIONS SUPPORTING THE PATIENT'S BILL OF RIGHTS ACT OF 1998

ABC for Health, Inc.
Access Living
AIDS Action
AIDS Law Project of Pennsylvania
Alamo Breast Cancer Foundation and Coalition
Alcohol/Drug Council of North Carolina
Alliance for Rehabilitation Counseling
Alzheimer's Association Greater Richmond Chapter
Alzheimer's Association NYC Chapter
American Academy of Child and Adolescent Psychiatry
American Academy of Emergency Medicine
American Academy of Neurology
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association for Respiratory Care
American Association of Children's Residential Centers
American Association of Nurse Anesthetists
American Association of Pastoral Counselors
American Association of Private Practice Psychiatrists
American Association of Retired Persons
American Association of University Women
American Association on Mental Retardation
American Autoimmune Related Diseases Association
American Board of Examiners in Clinical Social Work
American Cancer Society
American College of Emergency Physicians
American College of Obstetricians-Gynecologists (ACOG)
American College of Physicians
American Counseling Association
American Dental Association
American Federation for Medical Research
AFL–CIO
American Federation of State, County, and Municipal Employees
American Federation of Teachers
American Gastroenterological Association
American Group Psychotherapy Association
American Heart Association
American Lung Association
American Medical Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Network of Community Options and Resources
American Nurses Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Public Health Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Anxiety Disorders Association of America
Arc of Washington State
Asian and Pacific Islander American Health Forum
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Health Care
Association of Behavioral Health Care Management
Bazelon Center for Mental Health Law
Brain Injury Association
California Advocates for Nursing Home Reform
California Breast Cancer Organizations
Catholic Charities of the Southern Tier
Center for Patient Advocacy
Center for Women Policy Studies
Center on Disability and Health
Children and Adults with Attention Deficit Disorders
Child Welfare League of America
Children's Defense Fund
Clinical Social Work Federation
Coalition of Wisconsin Aging Groups
Colorado Ombudsman Program—The Legal Center
Communication Workers of America—Local 1039
Consortium for Citizens with Disabilities Health Task Force
Consumer Federation of America
Consumers Union
Corporation for the Advancement of Psychiatry
Crater District Area Agency on Aging
Dekald Development Disabilities Council
Delta Center for Independent Living
Disabled Rights Action Committee
Eastern Shore Area Agency on Aging/Community Action Agency, Case Management Department
Epilepsy Foundation of America
Families USA Foundation
Family Service America
Family Voices
Federation for Children With Special Needs
Florida Breast Cancer Coalition
Gay Men's Health Crisis
Gazette International Networking Institute (GINI)
General Clinical Research Center Program Directors Association
Genzyme
Glaucoma Research Foundation
Health and Medicine Policy Research Group
Human Rights Campaign
Independent Chiropractic Physicians
International Association of Psychosocial Rehabilitation Services
League of Women Voters
Mary Mahoney Memorial Health Center
Massachusetts Association of Older Americans
Massachusetts Breast Cancer Coalition
Meals on Wheels of Lexington, Inc.
Mental Health Association in Illinois
Mental Health Net
Minnesota Breast Cancer Coalition
National Abortion and Reproductive Rights Action League
National Alliance for the Mentally Ill
National Association for Rural Mental Health
National Association for the Advancement of Orthotics and Prosthetics
National Association of Children's Hospitals
National Association of Development Disabilities Councils
National Association of Homes and Services for Children
National Association of Nurse Practitioners in Reproductive Health
National Association of People with AIDS
National Association of Protection and Advocacy Systems
National Association of Psychiatric Treatment Centers for Children
National Association of Public Hospitals and Health Systems
National Association of Public Hospitals
National Association of School Psychologists
National Association of Social Workers
National Black Woman's Health Project
National Breast Cancer Coalition
National Caucus and Center on Black Aged, Inc.
National Consumers League
National Council for Community Behavioral Healthcare
National Council of Senior Citizens
National Hispanic Council on Aging
National Marfan Foundation
National Mental Health Association
National Multiple Sclerosis Society
National Parent Network on Disabilities
National Partnership for Women & Families
National Patient Advocate Foundation

National Therapeutic Recreation Society
NETWORK: A National Catholic Social Justice Lobby
Nevada Council on Developmental Disabilities
Nevada Council on Independent Living
Nevada Forum on Disability
Nevada Health Care Reform Project
New York City Coalition Against Hunger
New York Immigration Coalition
New York State Nurses Association
North Carolina State AFL–CIO
North Dakota Public Employees Association—AFT 4660
Oklahoman for Improvement of Nursing Care Homes
Older Women's League
Ombudservice
Oregon Advocacy Center
Paralyzed Veterans of America
Permanency Planning Services, Inc.
Physicians for Reproductive Choice and Health
President Clinton
Reform Organization of Welfare (ROWEL)
RESOLVE
Rhode Island Breast Cancer Coalition
Rockland County Senior Health Care Coalition
San Diego Federation of Retired Union Members (FORUM)
San Francisco Peakers Senior Citizens
Service Employees International Union
Service Employees International Union—Local 205
Service Employees International Union—Local 585, AFL–CIO CLC
South Central Connecticut Agency on Aging
Southern Neighborhoods Network
The ARC
Tourette Syndrome Association, Inc.
United Automobile, Aerospace & Agricultural Implement Workers of America (UAW)
United Cerebral Palsy Association
United Church of Christ, Office for Church in Society
Vermont Public Interest Research Group
Voluntary Action Center
Volunteer Trustees of Not-For-Profit Hospitals
West Side Chapter NCSC
Western Kansas Association on Concerns of the Disabled
Women in Touch

GROUPS ENDORSING H.R. 1415, THE PATIENT ACCESS TO RESPONSIBLE CARE ACT

Academy of General Dentistry
American Academy of Child and Adolescent Psychiatry
American Academy of Emergency Medicine
American Academy of Nurse Practitioners
American Association of Children's Residential Centers
American Association of Marriage and Family Therapy
American Association of Nurse Anesthetists
American Association of Oral and Maxillofacial Surgeons
American Association of Pastoral Counselors
American Association of Private Practice Psychiatrists
American Association of Psychiatric Services for Children
American Association of Psychosocial Rehabilitation
American Chiropractic Association
American College of Emergency Physicians
American College of Nurse-Midwives
American College of Radiology
American Counseling Association
American Dental Association
American Federation of Home Health Agencies
American Group Psychotherapy Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Optometric Association
American Orthopsychiatric Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Society of Radiologic Technologists
American Speech-Language-Hearing Association
American Student Dental Association
Anxiety Disorders Association of America
Association for Ambulatory Behavioral Healthcare
Association for the Advancement of Psychology
Association of Behavioral Healthcare Management
Center for Patient Advocacy
Children and Adults with Attention Deficit Disorder
Clinical Social Work Federation
Cooperation for the Advancement of Psychiatry
Family Service America
Home Health Services and Staffing Association
International Association of Psychosocial Rehabilitation Services
Medical Association of Georgia
National Alliance for the Mentally Ill
National Association for Home Care
National Association for Rural Mental Health
National Association of Protection and Advocacy Systems
National Association of Psychiatric Treatment Centers for Children
National Association of Social Workers
National Community Pharmacists Association
National Council for Community Behavioral Healthcare
National Federation of Societies for Clinical Social Work
National Kidney Foundation
National Mental Health Association
National Mental Health Association
Opticians Association of America
Partnership for Recovery
Betty Ford Center
Hazelden Foundation
Valley Hope Association
Research Institute for Independent Living

Mr. Speaker, people say, what is in this legislation? We have already addressed some of this. The funny thing about it when we are looking at all of the opponents to this legislation is that the majority of the Members of Congress have already voted for the majority of items that is in this legislation.

I have here, Mr. Speaker, a side-by-side comparison of the items in Medicare Plus Choice that this House passed last year as it relates to internal appeals, external appeals, access to care, information disclosure, gag rules, advance directives, provider incentives, nondiscrimination, confidentiality of medical records, provider protections, quality measurement, utilization review, health quality boards, and ERISA. I have a side-by-side comparison on this. It is an interesting thing when we talk about the liability issue. A Medicare person who chooses a Medicare Plus Choice plan has the ability to legally redress malpractice, but somebody who is not a Medicare patient cannot under ERISA. This is a side-by-side comparison. Mr. Speaker, I include this comparison for the CONGRESSIONAL RECORD, as follows:

COMPARISON OF PROTECTIONS IN MEDICARE+CHOICE V. PATIENTS' BILL OF RIGHTS

Issue	Medicare+Choice	Patients' Bill of Rights
Internal Appeals	Requires plans to have procedures for reconsideration of adverse decisions	Plans must establish procedures to allow ''appealable decisions'' to be appealed.
Time for Review	Appeal must be decided within 60 days of receipt	Normal appeals must be completed within 15 days (with extension for up to an additional 10 days).
Expedited Appeals	Generally must be decided within 72 hours	Same.
Qualifications of reviewer	Must be a physician or appropriate specialty not involved in original decision	Review by a ''clinical peer,'' who can be selected by the plan but who must not have participated in the original decision.
Notice of Decision	Patients must be sent a notice of decision and reasons for it. Also must be told of rights to a hearing if amount in controversy is greater than $100.	Patients and provider must be notified of decision and reasons for it and told of any further appeal rights.
External Appeals	External Appeals process must be available after all internal processes are exhausted	Plans must have a process for external appeals if decisions jeopardize a patient's health or exceed a ''significant threshold.''
Who conducts	The Secretary must contract with outside groups to handle these appeals	Plans must be done by independent and qualified third parties. There can be no financial incentives for these groups to affirm the plan's original denial.
Procedure and timeframe	Appeals are first sent to HCFA, which hears the appeal. If the appeal is again denied, the patient may have rights to a further hearing before an administrative law judge or a U.S. district court.	The external appeal must hear the issue de novo. Decisions must be made in 60 days, except exigent appeals (72 hours). Patients may have rights to further appeals in state court if the plan prevails on appeal.
Review body qualifications	No provision	Standards for external reviewers include: no conflict of interest, review by clinical peers, entity must have legal and medical expertise. Entity must be certified by the State or by HHS.
Costs	No provision	Plan must bear the costs of the appeal.
	ACCESS TO CARE	
General provisions	Requires plans to ensure benefits are accessible with reasonable promptness	Plan must have sufficient mix and distribution to deliver all benefits.
Point of service	Plans may offer enrollees a point of service option	Enrollees must have the option to purchase a point of service plan unless the insurance is provided through more than one issuer or two or more coverage options are offered.
Choice of specialist	Plans must have appropriate access to specialty care	Plans must allow enrollees to select the specialist of their choosing from the list of participating doctors, unless the plan clearly notifies enrollee of limitations on choice.
Ob-gyn care	No provision	Enrollee may designate ob-gyn as primary care provider. Plans may not require pre-authorization for routine ob-gyn care.
Standing referrals	No provision, but plans must make all care available with reasonable promptness	Enrolless with conditions that require on-going specialty care may get standing referrals.
Clinical trials	No provision	Plans may not discriminate against patients in approved clinical trials and must cover their routine costs.

COMPARISON OF PROTECTIONS IN MEDICARE+CHOICE V. PATIENTS' BILL OF RIGHTS—Continued

Issue	Medicare+Choice	Patients' Bill of Rights
Prescription drugs	No provision	Plans that use formularies must involve M.D.s and pharmacists in its selection; must disclose formulary to patients; and have a process for patients to get non-formulary drugs when medically necessary.
Emergency care	Prudent lay-person standard, etc	Similar provision.
	INFORMATION DISCLOSURE	
General	Secretary must mail to beneficiaries information helpful in selecting plans	Plans must provide information in a timely manner to enrollees. Should be done in a uniform way to allow people to compare different plans.
Specific information that must be disclosed.	Covered benefits, liability for non-covered services, and coverage of emergency services	Same.
Other disclosures	Beneficiary cost-sharing, caps on out of pocket spending, balance billing protections, description of appeal and grievance rights.	Same, plus availability of ombudsman assistance.
Information available upon request	Number of grievances and their aggregate disposition	Same, plus drug formulary information.
Comparative information	Plans must—to the extent possible—give enrollees comparative data on patient satisfaction and outcomes. Also give disenrollment rates.	Summary quality data on patient satisfaction, disenrollment, and the plan's loss ratio. On request, plans must provide information on how they keep information confidential.
Network characteristics	Plans must give enrollees; the number and mix of providers, out of network coverage, any point of service option, any other availability of care through out-of-network providers. Plans must also give HHS enough data to ensure they are in compliance with physician incentive (capitation) rules.	Plans must provide information on: the service area of the plan, out of area coverage, the extent to which benefits from out-of-network providers is available, how enrollees select providers, any point of service option, and the types of financial payments made to providers.
	On request, the plan also must provide a general description of physician payment arrangements.	Same.
Utilization review	Plans must inform enrollees about how utilization review procedures work Upon request, the plan must notify enrollees of their procedures to control utilization of services and expenditures.	Plans must provide information on any prior authorization or review requirements that could result in non-coverage or non-payment.
Provider credentials	No provision (focus is on plans, not providers)	Upon request, plans must make available information on provider credentials and a list of participating providers.
Gag Rules	Bans them, subject to conscience clause	Goes further, as it contains a broader definition of medical communication and protects speech to others within the plan (and also to the public in the whistleblower provision).
Advance Directives	Plans must have policies on advance directives, such as living wills and durable powers of attorney.	No provision.
Provider Incentives	Plans must follow federal law requirements on physician incentive plans and must provide HHS with data to ensure they are in compliance.	Similar provisions.
Non-Discrimination	Plans may not discriminate against individuals based on age, sex, health status (except ESRD status), genetic information, etc.	Similar provision.
Confidentiality of medical records	Plans must establish procedures to protect the privacy of individually identifiable enrollee information. Also requires them to have procedures to ensure accuracy of the records.	Similar provisions.
Ombudsman	No specific provision, but other provisions of law authorize states to establish programs to provide counseling and assistance to Medicare beneficiaries with their health insurance coverage. Funded through a user fee on Medicare+Choice plans.	Federal grant program for the creation and operation of state Ombudsman programs to help consumers choose their plans and to deal the grievances and appeals.
	PROVIDER PROTECTIONS	
Contracting procedures	Plans must have reasonable procedures for physician participation including notice of participation rules, written notice of adverse participation decisions, and a process for appealing those decisions.	Similar provisions. Also requires plans to consult with physicians regarding the plan's medical policies and procedures.
Non-discrimination in selection of providers.	Prevents discrimination based on class of licensure	Similar provision, plus a general prohibition on discriminating in selection based on race, color, sex, sexual orientation, age, etc.
Whistle blower	No provision	Prohibits retaliation against providers who disclose information to appropriate authorities after exhausting internal procedures.
	QUALITY MEASUREMENT	
General provisions	HHS must disseminate information on plan quality, including performance data, disenrollment rates, and enrollee satisfaction.	Plans must collect and share information in uniform manner, including: aggregate utilization, demographics of participants, mortality and morbity rates, enrollee satisfaction, grievance and appeals data, etc. Allows HHS to waive these requirements based on variations in the types of delivery systems.
Internal quality improvement	Medicare+Choice plans must have a quality assurance program that stresses health outcomes and provides for ongoing measurement of the quality of high volume and high risk services and the care of acute and chronic illnesses.	Plans must have ongoing quality assurance programs, with written procedures for systemic review of the quality of health care provided and its consistency with good medical practice. Must have a process for providers and patients to report possible quality concerns. The program must review the plan's drug utilization program. Further provides that these requirements can be met through accreditation by a national accrediting group that the Secretary of HHS says has standards as stringents as those in the bill. The Secretary may provide for variations as needed to reflect differences in plan design.
External quality improvement program	Medicare+Choice plans must have external review of the quality of inpatient and outpatient care and of their response to consumer complaints of poor quality care.	No provision.
	UTILIZATION REVIEW	
General provisions	No provision, but plans must meet rules for initial determination of care	Plans must do utilization review in accordance to written procedures developed with the input of appropriate physicians. Retrospective UR may not revise or modify pre-authorized determinations. Qualified health professionals must oversee review decisions and review a sample of adverse clinical decisions. Prohibits financial incentives to UR agents that result in inappropriate denials. Requires toll-free access of peer review personnel during business hours. Providers and patients dissatisfied with a UR decision must have an opportunity to discuss the decision with the plan's medical director (who has the authority to reverse the decision). Prior authorization decisions must be made within three days of receipt. UR of continued and extended care must be made within one business day. Retrospective review of services must be completed within 30 days. Notice of an adverse action must be writted and included the reasons for the denial and the process for appealing that decision.
Health Care Quality Board	No provision	Directs the President to establish an advisory board to provide information on issues relating to quality monitoring and improvement. The board shall identify, update, and share measures of group health plan quality, advise on the proper minimum data set and standardized formats for information on group health plans.
Mastectomy Stay	No provision	Plans may not limit in-patient stay to less than 48 hours for mastectomy and less than 24 hours for lymph node dissection. The patient is free to leave sooner if she decides to, but the plan may not provide any incentives to patient and provider to avoid these protections.
Breast Reconstruction	No provision	Plans that provide breast surgery as a covered benefit must provide coverage for reconstruction resulting from a mastectomy.
Adequate Reserves	Plans must be licensed under state law and meet state solvency requirements. Establishes a temporary waiver process for PSOs under certain circumstances.	No provision.
ERISA	No provision (though ERISA does not pre-empt a Medicare beneficiary from suing a Medicare+Choice plan for acts of negligence.	Amends ERISA to allow state causes of action to recover damages resulting in personal injury or death. The employer cannot be sued unless they exercise discretionary authority to make medical decisions.

Mr. Speaker, to continue, I will not go through every single item on here, except to point out that, time for review, Medicare Plus Choice, 60 plus days, except that today the President shortened that period. Patients' Bill of Rights, 15 days for a normal appeal, with an extension up to 10 days. Notice of decision. Who conducts the external appeals. Review of qualifications. These are all things that are in Medicare Plus Choice that we hear some of our colleagues oppose. I cannot understand how they could have voted for all of these provisions for Medicare Plus Choice and yet they oppose these items in a Patients' Bill of Rights as being, quote, too bureaucratic. I think that

we need patient protections, the Patients' Bill of Rights for all citizens, not just for the ones that we have already voted on for Medicare or for Medicaid.

Mr. PALLONE. Again, I may be being cynical, but I think the reality is that when we put most of those patient protections in the Medicare legislation, in our own Committee on Commerce which both the gentleman and I are a Member of, the bottom line is that when those came to the floor, because of the widespread clamor, if you will, by senior citizen organizations and groups that these protections should be part of the Medicare program, and rightly so, I think the leadership, the House Republican leadership and most of the Members were unwilling to not support that because they were concerned about the power, if you will, and the clout of the senior vote, that they did not want to be denying senior citizens, who vote often and regularly, those kinds of patient protections. A thank-you is due to the seniors and the power of the senior vote and the senior organizations to make sure that that happened, but at the same time it is not fair to deny those protections to everyone else who is under 65 or who happens to not have the benefit of a Medicare program. That is really what we are about here. We are saying that those kinds of patient protections should be available to anyone who has health insurance, who is in a managed care organization or an HMO.

I am glad that you brought this out. It again points out that these are not really anything radical, these are not anything unusual, we have already adopted them for the largest Federal health insurance program, Medicare.

I just wanted to go back, if I can, because I know that the gentleman from Iowa has put a lot of emphasis on the ability to sue and recover costs that is denied now under ERISA, and I talked a little bit about the patient protection with regard to specialty care. I know that, at least from the reports that I have been reading in the various publications that we get on Capitol Hill that those are two areas that the House leadership seems to be reluctant to deal with. It may not actually be part of anything that the Republican leadership ultimately puts together.

Mr. GANSKE. If the gentleman will yield, as a Republican, I have been in favor of legal reform. I have voted for securities litigation reform, I voted for medical malpractice reform. I have voted for product liability reform. But I think we have a problem with ERISA, because we have given basically total legal immunity to health plans. We have not given that legal immunity to any other industry in the country.

When I as a physician am treating a patient, I would never argue that I should have immunity from malpractice. I might argue for some reasonable changes, but I would never argue that I should not have any legal responsibility for malpractice. That is why physicians, nurses, other practitioners carry medical malpractice insurance. And so I think that it is a basic principle of American law that responsibility for decisions should lie where the decision is made. If an HMO is making medical decisions and that results in malpractice, then they ought to be legally liable for that.

In fact, on the front page of last Friday's USA Today, the very front page center story was exactly on this issue. What most American citizens do not realize is that quite frankly when their HMOs if they are through their employer are making decisions, their HMOs do not have any legal responsibility. In my opinion that is wrong, and, quite frankly, I think the vast majority of the House if they would vote on this issue would feel the same way. Would you want to be on the record as voting for legal immunity for an HMO when the HMO has made a malpractice decision?

Mr. PALLONE. Absolutely not.

Mr. GANSKE. I do not think I would want to be and I do not know too many of my Republican colleagues who would want to be on the record for giving an HMO legal immunity for causing somebody's death or disfigurement.

Mr. PALLONE. If I could recapture my time, this was done, as the gentleman pointed out, years ago when HMOs and managed care organizations were not the vehicle for most Americans to get their health insurance. Now this loophole which was there has grown into a tremendous loophole that exists actually for most Americans. I do not know what was being thought of at the time when this was voted on, but the bottom line is the circumstances have changed now, because so many more Americans are impacted by this loophole.

I just wanted to say briefly, if I could, I am not sure that everyone understands when we talk about this inability to sue or this exemption, if you will, from liability, exactly what we mean. The problem is that you can only sue to recover the costs of whatever procedure was needed but denied. You cannot sue for damages. In other words, I will use an example. If you lose, say, an arm or a leg or an eye and you end up victimized for the rest of your life because your HMO denied you the care that could have saved the limb or the eye, you cannot sue for anything other than the cost of what the medical procedure to save the limb or the eye would have been. You cannot sue for losing the body part or for the deterioration of your health condition. So basically you are able to recover a very, very limited amount that does not help you to deal with the problem and the damages that you have suffered. That is really what we are talking about.

Mr. GANSKE. If the gentleman would yield, the opponents to this legislation would say, well, if you pass legislation on this, it would increase the cost of premiums, and, therefore, some employers would choose not to insure their employees.

A recent survey by Kaiser Family and Harvard interviewed 800 small business executives exactly on this issue. They found that even if there were a mild increase in the cost of a premium related to this, that only 1 to 3 percent of those employers would change their coverage. But the interesting thing was that something like two-thirds of those small business owners and executives agreed with the need for legislation to close that loophole. You might ask, why is that? It is because they are also covered by HMOs. More than 50 percent of them have said, we have seen abuses by HMOs either in our employees or in our own families, and we think there should be a remedy for that.

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But I would just like to continue on something else that we are likely to hear about tomorrow, and that is that hopefully the Republican Health Task Force will at least enunciate some principles to legislation, even if we will not see any specifics written in the form of a bill. And one of those things that the GOP task force is looking at is the idea of health marts, and this is basically where you gather, you would extend ERISA to multiple employer working associations, otherwise known as MEWAs, or other groups, so it is an extension of the ERISA exemption.

And I have here a letter from Therese M. Vaughan, the commissioner, the State Insurance Commissioner from the State of Iowa, and she says:

> Dear Representative Ganske: We want to alert you to proposed legislation currently being discussed called HealthMarts. HealthMarts pose a serious concern on several levels . . . A few of our concerns are listed below for your review: The impact of State insurance markets.

She goes on in some detail. Several provisions would allow a health mart to cherry pick to ruin the risk pools. There are problems with Federal enforcement of State law. There are conflicts of interest.

I have a similar letter from Consumers Union on the problems related to health marts. Health marts, if you will remember, are very close to what the Clintons proposed in 1993 with regional groups. So when opponents to our Patient Bill of Rights have accused us of being ''Clinton Care'', I would sincerely hope that Republicans would not come up with a proposal that is much, much closer to the Clinton plan.

And finally let me say I have a letter here from Blue Cross/Blue Shield and the Health Insurance Association of America that says:

> Dear Representative Ganske: We are writing to express our opposition to proposals that would exempt certain health insurance arrangements, such as association health plans and multiple employer welfare arrangements, from State insurance law and regulatory authority.

Mr. Speaker, insert these 3 letters into the CONGRESSIONAL RECORD.

The letters referred to are as follows:

IOWA DEPARTMENT OF COMMERCE,
Des Mones, IA, June 18, 1998.

Re HealthMarts.

Hon. GREG GANSKE,
United States Representative, Washington, DC.

DEAR REPRESENTATIVE GANSKI: We want to alert you to proposed legislation currently being discussed called ''HealthMarts.'' HealthMarts pose a serious concern on several levels. These concerns are similar to those we have expressed in the past regarding other proposals that would exempt certain health insurance arrangements (such as association health plans (AHPs) and multiple employer welfare arrangements (MEWAs)), from state law and regulatory authority.

A few of our concerns are listed below for your review.

1. The impact of state insurance markets. HealthMarts would undermine state health reforms by fragmenting the health insurance marketplace. Recent reforms guarantee small employers access to health insurance markets. While insurers selling through HealthMarts would still have to pay premium taxes, other state pooling laws and requirements would be preempted. States require many different types of pooling arrangements. These arrangements are primarily designed to help spread risks through such mechanisms as reinsurance pools, medically indigent pools, and high risk pools. Since HealthMarts only have to meet the rating requirements of the state in which the HealthMart is organized, a HealthMart could organize itself in the state with the least restrictive requirements in order to sell a particular benefit package at a lower rate in a state with more restrictive requirements.

2. Cherry picking. Several provisions would allow a HealthMart to choose which risks it wanted to accept.

A HealthMart is allowed to determine what geographic area it will serve. This will allow a HealthMart to operate in areas that contain healthier populations.

A HealthMart may market selectively within its geographic limits, thus exacerbating the conditions established by allowing the HealthMart to choose its own geographic location.

With state mandated benefit requirements preempted, a HealthMart would be allowed to design its own benefit package. Benefit package design determines who will be interested in purchasing a particular product.

3. Federal enforcement of state law. HealthMarts continue to allow state officials to approve product offerings of licensed insurance entities. If an insurance commissioner denies the sale of a product offerings and the insurer, selling through a HealthMart, disagrees with the decision of the commissioner, the insurer could appeal to a federal regulatory authority. The federal agency would then review state law and determine if the insurance commissioner properly interpreted her own state law. If, in the view of the federal agency, the insurance commissioner did not make the correct decision, the federal agency would allow the sale of that product and enforce state law regarding that product. This creates the unique situation where the federal government enforces state law.

4. Conflict of Interest. Allowing sellers on the board of an entity intended to act as broker between seller and buyer creates a conflict of interest. HealthMarts will be accepting bids from all insurers within a certain geographic location. The insurers on the board will have access to those bids and may also have access to proprietary information on how the bids were put together. Board insurers would be able to underbid those insurers who do not serve on the board.

HealthMarts undermine the recent efforts undertaken by states to ensure their small business communities have access to affordable health insurance. Iowa's success over the past 7 years in the area of health care reform will be greatly diminished if this legislation is enacted.

We have supported purchasing pools through state legislation that protects the consumer by providing coverage within rate restrictions. We would be happy to work with you on the development of legislation to continue to enhance the ability of individuals and small groups to obtain adequate and meaningful health care coverage.

If you have any questions, please do not hesitate to contact me or my staff. We look forward to working with you on any issues you may have concerning health insurance coverage.

Sincerely.

THERESE M. VAUGHAN,
Commissioner.

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

June 4, 1997.

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

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

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

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

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

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

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

Sincerely,

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 4, 1998.

BLUE CROSS/BLUE SHIELD AND HIAA OPPOSE REPUBLICAN ''HEALTHMART'' PROPOSAL

DEAR COLLEAGUE: It's not often that I think the advice from HIAA and Blue Cross/Blue Shield bears repeating, but this time they got it right.

In a letter to Chairman Bliley of the Commerce Committee, the Blue Cross/Blue Shield Association and the Health Insurance Association of America have made clear their opposition to the ''HealthMart'' proposal being circulated by Rep. Bliley as a potential component of the upcoming Republican health reform proposal.

Their letter states that the HealthMart proposal ''would exempt health plans offered through a HealthMart from state benefit standards and requirements to pool all small groups for rating purposes.'' For those reasons, HealthMarts raise ''serious concerns regarding market segmentation and the ability of states to protect their residents.''

They conclude their letter by urging ''legislators to avoid legislation that unravels the market by helping a limited group of small employers at the expense of other individuals and small groups.''

I urge my colleagues to heed their advice.

Sincerely,

PETE STARK.

There are a number of proposals that I am concerned will be in the GOP Health Task Force plan that are not well-thought-out, that are even opposed by the industry, at least as much as some of the patient protection legislation. I am afraid that if you add a number of these additional controversial items to a patient bill of rights type protection, that they will in effect act as poison pills and ensure the defeat of this legislation.

And I would not gainsay anyone's motives on this, but I would simply ask my Republican colleagues to be aware of this potential problem when they put forth their GOP task force.

Mr. PALLONE. Again, if I could ask you to elaborate a little more on this, one of the concerns that I expressed earlier this evening is that the Republican Task Force would come out with patient protections that are less than what is in the Patient Bill of Rights or the PARCA bill, and that is still a concern. But I think what you are voicing now is an additional problem which is not only the possibility of not including some of these patient protections that we would like to see, but also the possibility of adding other things unrelated to patient protections that would sort of muddy the water, if you will, and maybe confuse what goes on here and take away from this issue of patient protection which we are trying to bring forward.

And I know that one of the things I believe you mentioned was the medical malpractice cap, I guess, that we have

discussed in the past, and that is something that would.

Mr. GANSKE. If the gentleman would yield, I have argued on the floor, I have encouraged my colleagues, Republican and Democrat, to vote for medical malpractice reform. In fact, the House of Representatives passed that legislation in the last Congress, but we found out that we could not get that through the Senate, and the administration is opposed to it. To put that into a Patient Bill of Rights, a consumer protection bill, would be to realize fully that that bill could not pass, it could not become law.

I continue to be in favor of that legislation, but what I want to see is, I want to see a Patient Bill of Rights passed and become law this year. I think most of the major medical organizations, including the American Medical Association, recognize by loading up other issues into a Patient Bill of Rights you are working to defeat a Patient Bill of Rights, not to advance it.

Mr. PALLONE. Did not the AMA, which has been the biggest supporter of this medical malpractice reform, even say at one point that they did not want to deal with it this year in the context of the patient protections for the exact reason that you just cited, which is very amazing to me because this was always their biggest, one of their biggest, concerns.

Mr. GANSKE. I cannot speak. I am not a representative for that organization. All I can say is I am sure that that organization would like to see those provisions become law at some point in time, but the recognition is there that on this piece of legislation that will be considered a poison pill. We have broad bipartisan consensus and support for a limited Patient Bill of Rights like is in the Patient Bill of Rights bill, 3605, or Patient Access to Responsible Care Act.

It is not like you have to reinvent the wheel. These bills have been out there for some time. They already have broad bipartisan support. It is simply a matter of bringing them to the floor for a debate under a fair rule in a timely fashion before this session runs out.

Mr. PALLONE. Can I just ask you one more thing about the health marts, because I was not sure I understood.

You said that your concern is that ERISA exemptions would be expanded beyond what they already are now to cover health marts? In other words, we would actually have to deal with this exemption from liability in an even broader fashion?

Mr. GANSKE. That would be my understanding, and let me just read from this letter from Blue Cross/Blue Shield Association and the Health Insurance Association of America.

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

And I can assure you, as somebody that speaks to a number of insurance companies located in my own district that still provide insurance to individuals outside of the employer market, that if you created this health mart idea, what you would be doing is you would be taking the healthy individuals out of that individual market, thereby making the individual market more sick. That would, therefore, have the effect of raising the premiums significantly for those who still purchase their own health insurance.

And there are a lot of people like that; farmers, for example. I represent a lot of farmers.

So I would certainly advise the GOP Task Force not to include this type of proposal in their health care legislation, but simply to stick with the gentleman from Georgia (Mr. Norwood) who has worked on that task force so strongly in terms of a Patient Bill of Rights.

And you need to remember also that there are a number of HMOs that are trying to do an ethical, good job on providing care for their constituents, and many of them have already called upon Congress to pass Federal legislation for a Patient Bill of Rights. We have Kaiser, for instance, or the Health Insurance Plan, HIP, and others. They see a benefit in having some federally-enforceable minimum standards.

It is very similar to what we see if you were buying an automobile. Gee, I mean when you buy an automobile, you know that you are getting headlights that work, brakes that work, turn signals, a seat belt. Those are all a product of Federal and State law for minimum safety standards, and yet there continues to be a great deal of competition in the auto industry. By having some uniform rules on that, we certainly have not moved to a nationalized auto industry any more than by passing a Patient Bill of Rights and having some uniform safety standards would we ever be moving towards a nationalized health insurance system. It is just a matter of common sense.

Mr. PALLONE. I think there is no question that, you know, what we are really talking about here are just basic protections, common sense protections, and as the gentleman has pointed out, the not-for-profit HMOs actually from the very beginning of this year when the President first came out with his patient bill of rights in, I guess it was in his State of the Union address, and there were I think 18 points at that stage or 18 types of protections that were being discussed by the White House, and actually we had many of the not-for-profit HMOs supporting those principles because they are really a floor. They are just a floor of basic protections.

And what happens is, and again I think you mentioned this at some point in the past, is that if the not-for-profit or the good HMOs, whatever their characterizations would be, adhere to these patient protections and then the other ones that are for-profit or for whatever reason do not, it basically creates a noncompetitive situation, becomes cheaper, if you will, for the ones that are not providing the protections to operate.

Mr. GANSKE. And if the gentleman would yield, we have our July 4th recess coming up soon. I would hope that organizations like some of the ones that I have read tonight, all the other organizations that are signed on to passing this type of legislation this year would contact their Congressman and Congresswoman back in their districts and express to them the importance and how this affects real people a lot of the time and how Congress should do something about this this session and not allow this legislation to be bottled up.

Mr. PALLONE. And following up on your comments, and I guess I will close with this:

We know that during this 2-week recess that many Members, including myself, will be having town meetings and forums at which time there will be opportunities for groups or individuals to go to those town meetings and express to their Member of Congress their support and ask them to support the Patient Bill of Rights, or actually ask them to support the discharge petition that you and the gentleman from Michigan (Mr. DINGELL) have now introduced. We need to get as many Members as possible on this discharge petition because, if we can get a majority on the discharge petition by the time we come back or soon after that in the weeks that follow, we can finally bring the Patient Bill of Rights or the PARCA bill, these types of managed care reforms, to the floor.

And again I just want to commend you for your effort in moving in that direction because this is the time. If we are not going to pass this now when there is so much support for it, we are never going to pass it, and we have got to try and get more and more of our colleagues on board.

Mr. GANSKE. If the gentleman would yield, I appreciate the courtesy of being able to do these special orders with you. As I said before earlier in this special order, I would sincerely hope that a discharge petition is not necessary, that the Republican leadership in the House would set a date certain for bringing this legislation to the floor and make sure that it is with a rule that is fair and not a rule similar to the one that we have seen on campaign finance reform.

Mr. PALLONE. Mr. Speaker, I agree with the gentleman and thank him again.

ENDING DISCRIMINATION IN AMERICA

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. PELOSI) is recognized for 5 minutes.