economic growth, over 4 million jobs, and it approaches almost $1 trillion in terms of our gross national product. In my State of Oregon, the effects have been even more profound. We are known, for example, for agriculture and wood products. Yet technology-based industries in the State of Oregon now provide twice the economic impact as agriculture and forest products combined. It provides an average wage that is almost twice the State average. There is every indication as far as the future is concerned that the impact nationally and in the State of Oregon in the years ahead is going to be even more profound. Yet the question is, how do we take maximum advantage of this growing economic and sociological phenomenon.

It would seem to me that it is important for the Federal Government to have in place a series of policies that promote the full implementation of this opportunity. There has been significant indirect Federal support through the research and development tax credit that has helped invest in the future as far as these industries are concerned. Again, just taking the impact on a small State like Oregon where 8 percent of the total revenue is tied up in research and development, well over $1.3 billion.

But it is time for us in the Federal Government to get real about what our policy is towards stability in the high-tech industry. We have had in place for years a temporary investment tax credit that we approve a year at a time. We are going to extend the investment tax credit, once again due to expire. I hope that this year is the last time we go through this charade of the 1-year extension. We know that it is critical for the future of the high-tech industry. We know that it is a benefit that is well-placed, that pays dividends far in excess of the amount of benefit that is granted. Indeed, there is every indication that, according to one estimate, over $41 billion of new investment would be unleashed by making the investment tax credit permanent. Nobody in the private sector, however, is going to make the long-term investments based on our good intentions. Even though we know we are going to extend it, even though they are certain we probably will extend it, it simply is not prudent for people to put millions of dollars, tens of millions of dollars or more on the line based on our good intention. We have seen train wrecks on the floor of this Chamber before.

I hope that Members on both sides of the aisle will come together quickly to make clear that we are going to make this a permanent extension. Livable communities, I have suggested time and again on the floor of this Chamber, require not so much rules and regulations as they require the Federal Government to be a constructive partner with State and local governments, with private citizens and business to help promote livable communities. The stability that would come from a permanent extension of the investment tax credit would be a very tangible expression of that stable Federal partnership, and I hope we are about that business soon in this congressional session.

MANAGED CARE REFORM

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

Mr. GANSKE. Madam Speaker, tomorrow on the other side of the Capitol, in the Senate, debate begins on managed care reform legislation.

I would like to take my colleagues back to May 30, 1996, when a small, nervous woman testified before the House Committee on Commerce. Her testimony, Madam Speaker, was buried in the fourth panel at the end of a long day about the abuses of managed care. The reporters were gone, the television cameras had packed up, most of the original crowd had dispersed.

□ 1615

Madam Speaker, she should have been the first witness that day, not one of the last. She told about the choices that managed care companies and self-insured plans are making every day when they determine medical necessity.

This woman, Linda Peeno, had been a claims reviewer for several HMOs. Here is her story:

''I wish to begin by making a public confession. In the spring of 1987, as a physician, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred. I was rewarded for this. It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate I could do what was expected of me, I exemplified the good company doctor. I saved half a million dollars.''

Madam Speaker, as she spoke, a hush came over the room. The representatives of the trade associations who were still there averted their eyes. The audience shifted uncomfortably in their seats, both the gripped and alarmed by her story.

Her voice became husky, and I could see tears in her eyes. Her anguish over harming patients as a managed care reviewer had caused this woman to come forth and bear her soul.

She continued:

''Since that day I have lived with this act and many others eating into my heart and soul. For me a physician is a professional charged with the care or healing of his or her fellow human beings. The primary ethical norm is: Do no harm. I did worse; I caused death.''

She went on:

''Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools: my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment. When any moral qualms arose I was to remember I am not denying care, I am only denying payment.''

Madam Speaker, by this time the trade association representatives were staring at the floor, the Congressmen who had spoken on behalf of the HMOs were distinctly uncomfortable and the staff, several of whom subsequently became representatives of HMO trade organizations, were thanking God that this witness came at the end of the day.

Dr. Peeno's testimony continued:

''At the time this helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize this action. I accept my responsibility now for this man's death as well as for the immeasurable pain and suffering many other decisions of mine caused.''

She then listed the many ways managed care health plans deny care to patients, but she emphasized one particular issue: the right to decide what care is medically necessary.

She said:

''There is one last activity that I think deserves a special place on this list, and this is what I call the smart bomb of cost containment, and that is medical necessities denials. Even when medical criteria is used, it is rarely developed in any kind of standard traditional clinical process.''

She continued:

''It is rarely standardized across the field. The criteria is rarely available for prior review by the physicians or the members of the plan. We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry.''

After exposing her own transgressions, she closed by urging everyone in the room to examine their own consciences:

''One can only wonder how much pain, suffering and death we will have before we have the courage to change our course. Personally, I have decided even one death is too much for me.''

Madam Speaker, the hearing room at that time was stone cold quiet. The chairman mumbled, ''Thank you, Doctor.''

Linda Peeno could have rationalized her decisions, as many do. Oh, I was just working within guidelines, or I was just following orders, or, you know, we have to save resources, or this is not about treatment, it is really just about benefits.

Madam Speaker, Dr. Peeno refused to continue this denial, and she will do penance for her sins the rest of her life by exposing the dirty little secret of HMOs determining medical necessity.

Madam Speaker, if there is only one thing to consider before our colleagues

vote on patient protection legislation, I urge our colleagues to consider the following:

Before we vote on any patient protection legislation, we must keep in mind the fact that no amount of procedural protection or schemes of external review can help patients if insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage. As Dr. Peeno so poignantly observed, insurers now routinely make decisions by determining what goods and services they will pay for. The difference between clinical decisions about medical necessary care and decisions about insurance coverage are especially blurred, and, Madam Speaker, because all but the wealthy rely on insurers, the power of insurers to determine coverage gives them the power to dictate professional standards of care.

Make no mistake. Along with the question of health plan liability, the determination of who should decide when health care is medically necessary is the key issue in patient protection legislation.

Contrary to the claims of HMOs that this is some new concept, for over 200 years most private insurers and third party payers have viewed as medically necessary those products or services provided in accordance with prevailing standards of medical practice, quote, unquote. This is the definition that I use in my own managed care reform bill, the Managed Care Reform Act of 1999, and the courts have been sensitive to the fact that insurers have a conflict of interest because they stand to gain financially from denying care and have used clinically-derived professional standards of care, the courts have, to reverse insurers' attempts to deviate from those standards. That is why it is so important that managed care reform legislation include an independent appeals panel with no financial interest in the outcome. A fair review process utilizing clinical standards of care guarantees that the decision of the review board is made without regard to the financial interests of either the HMO or the physician. On the other hand, if the review board has to use the health plan's definition of medically necessary, there is no such guarantee.

Now, Madam Speaker, in response to a growing body of case law and the HMOs' own need to demonstrate profitability to their shareholders insurers are now writing contracts that threaten even this minimal level of consumer protection. They are writing contracts in which standards of medical necessity are not only separated from standards of good practice but are also essentially not subject to review.

Here is one example of many of a health plan's definition of medically necessary services. This is directly from the language of a contract from an HMO:

''Medical necessity means the shortest, least expensive or least intense level of treatment, care or service rendered or supply provided as determined by us, the health plan.''

Contracts like this demonstrate that some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not the patient's medical needs.

Now on the surface some might say, so what is wrong with the least expensive treatment? Well, let me give my colleagues one example out of thousands I could cite:

Before I came to Congress, I was a reconstructive surgeon. I treated children with cleft palets, a fissure on the roof of the mouth. Clinical standards of care would determine that the best treatment is surgical correction, but under this HMO's definition, the one that says shortest, least expensive, the plan could limit coverage to a piece of plastic to fill the hole in the roof of that patient's mouth. After all, that plastic obturator would be cheaper. However, instead of condemning children to a lifetime of using a messy prosthesis, the proper treatment, reconstruction using the child's own tissue, would give that child the best chance at normal speech and a normal life, and let me warn my colleagues paradoxically insurers stand to benefit from misguided legislative changes that can displace case law.

Last year legislation passed this House and the GOP bill in the Senate would have granted insurers the explicit power to define medical necessity without regard to current standards of medical practice. This would have been accomplished by allowing them to classify as medically unnecessary any procedures not specifically found to be necessary by the insurer's own technical review panel. The Senate bill also would have given insurers the power to determine what evidence would be relevant in evaluating claims for coverage and would have permitted insurers to classify some coverage decisions as exempt from administrative review.

Madam Speaker, I know that many of our colleagues who supported those bills last year had no idea of the implication of the medical necessity provisions in them.

☐ 1630

That is why I hope my friends in both the House and the Senate are listening. As I said, tomorrow the Senate starts to address this issue.

Specifically, insurers now want to move away from clinical standards of care applied to particular patients to standards linking medical necessity to what are called population studies.

On the surface, this may seem to be scientific and rational. However, as a physician who is a former medical reviewer myself and who worked with many insurers, large and small, let me explain why I think it is critical that we stick with medical necessity as defined by clinical standard of care.

First, sole reliance on broad standards from generalized evidence is not good medical practice. I will explain these. Second, there are practical limits to designing studies that can answer all clinical questions. Third, most studies are not of sufficient scientific quality to justify overruling clinical judgment.

Let me explain these points, and I also recommend an article on this by Rosenbaum in the January 21, 1999, edition of the New England Journal of Medicine.

First, while it may seem counterintuitive, it is not good medicine to solely use what are called outcomes-based studies of medical necessity, even when the science is rigorous. Let me explain why.

The reason is because the choice of the outcome is inherently value laden. The medical reviewer for the HMO is likely, as shown by the above-mentioned contract, to consider cost the essential value.

What about quality? As a surgeon, I treated many patients with broken fingers merely by reducing the fracture and splinting the finger and, Madam Speaker, for most patients this inexpensive treatment would restore adequate function.

What about the musician, the piano player who needs a better range of motion? For that patient, surgery might be necessary.

Which outcome should be the basis for the decision about insurance coverage? Playing the piano or routine functioning?

My point is this: Taking care of patients requires a lot of variation and a lot of individualization. Definitions of medical necessity have to be flexible enough to take into account the needs of each patient. One-size-fits-all outcomes make irrelevant the doctor's knowledge of the individual patient and is bad medicine, period.

Second, there are practical limitations on basing medical necessity on what is called generalized evidence, particularly as applied by HMOs.

Much of medicine is a result of collective experience, and many basic medical treatments have not been studied rigorously. Furthermore, aside from a handful of procedures that are not explicitly covered, most care is not specifically defined in health plans because the number of procedures and the circumstances of their application is limitless.

In addition, by their very nature, many controlled clinical trials study treatments in isolation; whereas physicians need to know the benefits of one type of treatment over another when they are taking care of an individual patient. Prospective randomized comparison studies, on the other hand, are very expensive. Given the enormous number of procedures and individual circumstances, if coverage is limited to only those that have scientifically sound generalized outcomes, care could be denied for almost all conditions.

Come to think of it, Madam Speaker, maybe that is why HMOs are so keen to

get away from prevailing standards of care.

Third, the validity of HMO guidelines and how they are used is open to question. Medical directors of HMOs were asked to rank the sources of information they used to make medical decisions. Industry guidelines, generated by the trade associations representing health plans, were ranked ahead of information from national experts, government documents and NIH consensus conferences. The most highly respected source, medical journals, was used less than 60 percent of the time.

Industry guidelines are frequently written by a firm by the name of Milliman and Robertson, a strategy shop for the HMO industry. This is the same firm that championed drive-through deliveries and outpatient mastectomies. Many times these practice guidelines are not grounded in science but are cookbook recipes derived by actuaries to reduce health care costs.

Here are two examples of the errors of their guidelines. In reference to outpatient mastectomies, a National Cancer Institute study released in June found that women receiving outpatient mastectomies face significantly higher risks of being rehospitalized and have a higher risk of surgery-related complications like infections and blood clots. In regard to drive-through deliveries, in 1997, a study published in the Journal of the American Medical Association showed that babies discharged within a day of birth faced increase risk of developing jaundice, dehydration and dangerous infections.

Objectivity of medical decision-making requires that the results of studies be open to peer review, yet much of the decision-making by HMOs is based on unpublished proprietary and unexamined methods and data. Such secret and potentially biased guidelines simply cannot be called scientific.

This is not to say that outcomes-based studies do not make up a part of how clinical standards of care are determined. They do, but we are all familiar with the ephemeral nature of new scientific studies such as those on the supposed dangers of alar. Remember the apple scare a few years ago?

Clinical standard of care, the standard that we should use for medical necessity, does take into account valid and replicable studies in the peer-reviewed literature, as well as the results of professional consensus conferences, practice guidelines based on government-funded studies and guidelines prepared by insurers that have been determined to have been free of conflict of interest, but most importantly, they also include the patient's individual health and medical information and the clinical judgment of the treating physician.

Madam Speaker, Congress should pass legislation defining this standard of medical necessity because, one, the Employee Retirement Income Security Act, ERISA, shields plans from the consequences of most decisions about medical necessity. Two, under ERISA, patients generally can only recover the value of the benefits denied. Three, even this limited remedy is being eroded by insurance contracts that give insurers the authority to make decisions about medical necessity based on questionable evidence.

To ensure these protections, Congress must provide patients with a speedy external review of all coverage decisions, not merely those that insurers decide are subject to review. It is time for Congress to defuse the smart bomb of HMOs.

Madam Speaker, the issues of managed care reform should go from the drawing board to the signing ceremony this year. Last year, I joined with the gentleman from Michigan (Mr. DINGELL) and offered the Patients' Bill of Rights as an amendment on the House floor. While I regret that it did not pass, there may have been at least one good thing about that. In the last few weeks, many HMOs have announced double digit premium increases. We can be sure that if the Patients' Bill of Rights had passed, there would be a whole lot of HMO fingers pointing at Congress blaming us now for those skyrocketing premiums which are really due to HMO mismanagement.

I think it is important to remember why it is so important that Congress should pass HMO reform legislation. I will bet, Madam Speaker, that every one of our colleagues has heard from constituents describing their own HMO horror story.

We have all seen headlines like, HMO's rules leave her dying for the doc she needs, or ex-New Yorker is told get castrated so we can save dollars. Or how about this headline: What his parents did not know about HMOs may have killed this baby.

Consider the 29-year-old cancer patient whose HMO would not pay for his treatments. The HMO case manager told him instead to hold a fund-raiser, a fund-raiser.

Well, Madam Speaker, we just had an hour of debate about campaign fund-raising. I certainly hope that campaign finance reform will not stymie that man's chance to get his cancer treatment.

During congressional hearings 2 years ago we heard testimony from Alan DeMeurers who lost his wife Christy to breast cancer. When a specialist at UCLA recommended she undergo bone marrow transplant surgery her HMO leaned on UCLA to change its medical opinion. Who knows whether Kristi would be with her two children today had her HMO not interfered with her doctor/patient relationship?

Other plans have placed ridiculous burdens on those seeking emergency care. Ask Jacqueline Lee how bad that can be. This 28-year-old lady was hiking in the mountains, just west of Washington, D.C. in the Shenandoah Mountains when she fell off a 40-foot cliff. She fractured her skull, her arm, her pelvis. She was comatose, lying at the bottom of this 40-foot cliff. Fortunately, her hiking companion had a cellular phone and she was airlifted to a local hospital and she was treated in the ICU for a month on morphine drips.

Now, one will not believe this. Her HMO refused to pay for the services because she failed to get preauthorization. I ask, what was she supposed to do with her fractured skull, her broken arm, her broken pelvis, lying at the base of the cliff? Maybe wake up from her coma with her nonbroken arm, pull a cellular phone out of her pocket, dial a 1–800 phone number and say, hey, I just fell off a 40-foot cliff; I need to go to the hospital?

There are countless other examples. A pediatrician who worked in this area took care of a pediatric ICU. She told me about how a few years ago, a 6-year-old boy came into her ICU, after drowning. Prognosis was terrible. The little boy had been in the unit about 5 hours. They had him intubated. They had the drips running. Doctors and nurses and family were standing around the bed praying for a sign of life when the phone rings. It is a medical manager from the HMO.

Well, tell me about this little boy.

Well, he nearly drowned. The prognosis is not very good.

Now, one can almost picture the computer screen and the algorithm from this medical manager a thousand miles away. Ventilator patient, poor prognosis.

Well, came the next question, have you considered sending this little boy home on home ventilation? After all, it is cheaper.

Think about that. Does not that just about make the hair stand up on the back of your head? That is what we are dealing with.

□ 1645

Madam Speaker, because our friends and our neighbors and our fellow workers and our own families have had these types of experiences, countless polls show that people want Congress to pass managed care reform.

A recent Kaiser Family Foundation survey found that 78 percent of voters support managed care reform, and a similar percentage support allowing consumers to go to court to sue their health plans when those health plans are negligent. No public opinion poll, however, conveys the depth of emotion on this issue as well as movie audiences around the country who spontaneously clapped and cheered Helen Hunt when she gave an obscenity-laced evaluation and description of her HMO in the Oscar-winning movie, ''As Good As It Gets.'' Audiences across the country responded to the plight of her little boy with asthma because they see the same thing happening to their friends, their neighbors, and their family members.

The industry responds by saying, Christy DeMeurers, Jacqueline Lee, this little boy who has just drowned,

they are just anecdotes; we do not legislate because of anecdotes. Well, Madam Speaker, to paraphrase Shakespeare, Hath not these anecdotes, these HMO victims, eyes? Hath not these anecdotes hands, organs, dimensions, senses, affections, passions? If you prick the anecdotes, do they not bleed? And if you cut short their care for profits, do those anecdotes not die?

Madam Speaker, I hope we never hear that word anecdote when we debate this issue on the floor this year.

Last year, I and a few other brave souls crossed party lines to push for passage of the Patients' Bill of Rights. It was a good bill, and it would have done a great deal to end the constant stream of HMO horror stories. It contained, for example, very strong language ensuring that health plans pay for emergency care.

Consider the plight of James Adams, aged 6 months old. At 3:30 in the morning, his mother, Lamona, found him hot, panting, and moaning. His temperature was 104 degrees. Lamona phoned her HMO and was told to take little Jimmy to the Scottish Rite Medical Center. Quote: ''That is the only hospital I can send you to,'' the HMO reviewer added. ''How do I get there,'' Lamona asked. ''I don't know,'' the nurse said. ''I am not good at directions.''

Well, it turns out that Scottish Rite Hospital was about 70-some miles away. So, at 3:30 in the morning, Lamona and her husband wrap up little Jimmy, put him in the car. Picture this: It is a stormy night. They start their drive to the hospital. Madam Speaker, 20 miles into their ride they passed Emory University Hospital, a renowned pediatric center. Nearby were two more of Atlanta's leading hospitals, Georgia Baptist and Grady Memorial. But the Adams did not have permission to stop there, and so they pushed on. They had farther to go to get to Scottish Rite Hospital. While searching for the hospital, James' heart stopped.

There is a scene in the movie that is out now, A Civil Action, showing a mother and a father in a car on the side of the road on a stormy night administering CPR to their child. Think of Jimmy Adams when you see that movie.

Well, Lamona and her husband eventually got Jimmy to Scottish Rite. It looked like the boy would die. But he was a tough little guy, and despite his cardiac arrest, due to delay in treatment by his HMO, he survived. However, the doctors had to amputate both of his hands and both his feet because of the gangrene that resulted from his cardiac arrest.

All of this is documented in the book, Health Against Wealth, and as the details of Baby James' HMO's methods were emerged, it became clear that the margins of safety in that HMO were razor thin. Maybe as thin as the scalpel that had to amputate both this little boy's hands and both of his feet. For the rest of his life, this little boy will never be able to play basketball. I talked to his mother last week. He has learned how to put on his leg prostheses without his bilateral hooks, but he cannot get on his bilateral hooks unless he has help from his mom. He will never be able to touch and caress the cheek of the woman that he loves some day.

Think of the dilemma an HMO places on a mother struggling to make ends meet. In Lamona's situation, if she rushes her child to the nearest emergency room, she could be at risk for hundreds or even thousands of dollars because she was not given authorization. It was not medically necessary to go to that nonprovider hospital. Or, she could hope that her child's condition will not worsen as they drive past one hospital after another, an additional 20 miles, to get to the nearest emergency room affiliated with their plan.

Madam Speaker, a strong HMO reform bill would ensure that consumers would not have to make that potentially disastrous choice.

Now, in recognition of problems in managed care, three managed care plans joined with Families USA and other consumer groups in 1997 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, and 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.''

After listening to some of these examples of the victims of managed care, I would certainly agree with them, that we need some Federal standards to correct the abuses, and from the viewpoint of the plans, they certainly have a public relations disaster.

These plans said that they noted that they already make extensive efforts to improve the quality of care, and the Chief Executive Officer of the one plan said quote, ''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 result.''

Let me repeat that. The Chief Executive Officer of one of these nonprofit plans said, ''We are more than willing to see laws enacted to ensure that result.'' However, I am sad to say that despite strong public support to correct problems like these and the support of some responsible managed care plans, legislation stalled in Washington last year. That is truly unfortunate, since the problem demands Federal action.

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 regulations. Now, how is this possible?

Well, more than two decades ago, Congress passed the Employee Retirement Income Security Act. As I have said before, this is called ERISA. It did this to provide some uniformity for pension plans in dealing with different State laws. Health plans were included in ERISA, almost as an afterthought. But 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.

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

Now, many of the opponents to this legislation say, well, we will end up, if we pass this, with nationalized health insurance. It is always the big bogeyman, nationalized health insurance. But I ask my colleagues, think for a moment about buying a car. Federal laws ensure that cars have horns and brakes and headlights and seatbelts; they also ensure that they do not pollute. 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. One does 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 seatbelts has led to a nationalized auto industry. In a free market, these minimum standards set a level playing field that allows competition to flourish.

Before closing, Madam Speaker, let me share some thoughts on how I think this issue will evolve in the coming months. As we know, we came close to passing the Patients' Bill of Rights last year in part, because I and some other Republicans crossed party lines to support the better bill. Already I see signs this year that the fight could break out the same way. We simply cannot let the issue of managed care reform die on the cross of partisanship.

So I decided not to cosponsor the Patients' Bill of Rights when it was introduced earlier this year. Instead, I introduced my own bill: The Managed Care Reform Act of 1999, H.R. 719. While my bill shares the best features of other leading managed care reform proposals, it also eliminates some provisions that would add regulatory burdens on health plans without providing

much in the way of added patient safety. In addition, the bill has a new formulation on the issue of health plan liability. I continue to believe that health plans which make negligent medical decisions should be accountable for their actions.

But a winning lawsuit is little consolation to a family who has lost a loved one. The best HMO bill ensures that health care is delivered when it is needed, and I also believe that the liability should attach to the entity that is making medical decisions.

Many self-insured companies contract with large managed care plans to deliver care. If the business is not making discretionary decisions, they should not face liability. This is true of folks like third-party administrators if they merely perform administrative functions. But if they cross the line and determine whether a particular treatment is medically necessary; remember, this brings us back to the medical necessity issue that I started this speech about. If they cross that line in a given case, then they are making medical decisions, and they should be responsible for their actions.

To encourage health plans to give patients the right care without having to go to court, my bill provides for both an internal and an external appeals process. But unlike last year's Republican bill, the external review is binding on the plan.

□ 1700

It could be requested by either the patient or the health plan. The review would be done by an independent panel of medical experts. Frequently, patients pursuing cases through appeal win. They win their treatment. But many times, also, the plan's decision is proven to be the right one.

My bill provides that, if the plan follows the definition of the external review panel, there could not be punitive damages liability on either the health plan or the business. After all, there cannot be any malice if they have bound themselves to the decision of an independent panel of experts.

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

That is why my plan should be attractive to both sides. Consumers get a reliable and quick external appeals process that will help them get the care that they need. They can go to court to collect economic damages like lost wages and future medical care and noneconomic damages like pain and suffering.

If the plan fails to follow the external reviews decision, the patient can sue for punitive damages. But if it has gone in a timely fashion through the review process to that independent panel for a binding decision on the plan, that plan then knows that it has no punitive damages liability. That is the big unknown to an insurance company. That eliminates for them the risk of a $50 million or $100 million punitive damages award. But they have to follow the recommendations of that independent review panel.

I have heard from insurers that they fear that this legislation will cause premiums to increase. I think there is ample evidence that this would not be the case. Last year, the Congressional Budget Office estimated that a similar proposal, which did not include punitive damages relief, would only increase premiums around 2 percent over 10 years.

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

The low estimate by Scott and White seems accurate since only one suit has been filed against a Texas health plan since Texas passed legislation similar to this. That is far from the flood of litigation that opponents predicted.

Madam Speaker, I have been encouraged by the positive response my bill has received. I think this could be the basis for a bipartisan bill this year. In fact, I spoke with the CEO of a large Blue Cross plan who confided to me that his organization is already implementing virtually all of the recommendations of the President's Health Care Quality Advisory Commission for little or no cost.

One part of the health care debate that concerns him is the issue of liability. He has indicated that shielding plans from punitive damages when they follow an external review body would strike an appropriate balance.

Madam Speaker, passage of real patient protection legislation is going to require a lot of hard work, dedication, and some compromise. My new bill represents an effort to break through this partisan gridlock and move this issue forward.

I hope to work with all my colleagues to help break the logjam keeping patient protection legislation from becoming law. This issue is vitally important to families across this country.

To my fellow legislators, please do not let the insurers define ''medically necessary'' or someday my colleagues or a family member or a friend will find themselves defined out of a treatment that is a clinical standard of care that could save their life or the life of somebody else.

RACISM, DEADLY DIFFERENCES AND DIVERSITY PROBLEMS

The SPEAKER pro tempore (Mrs. BIGGERT). Under the Speaker's announced policy of January 6, 1999, the gentleman from New York (Mr. OWENS) is recognized for 60 minutes.

Mr. OWENS. Madam Speaker, I would like to address a number of issues that I think are very much related to the problem of racism, of deadly differences, and diversity problems that have broken out all over the world and we are part of trying to resolve.

A lot of them occur right here at home. In my own city of New York, a poll was taken that showed, and the New York Times announced today, that one-fourth of all New Yorkers, white and black New Yorkers, believe that the police of New York City behave quite differently with people of color, with minority groups, African Americans, Hispanics, and Asians, they behave quite differently with them than they do with whites. Whites as well as blacks have come to this conclusion. One-fourth of all the citizens of New York believe that this is the case.

So we have a serious problem right at home with a very crucial body of people, the police, who are so vital to the law and order of the city for everybody, everybody's protection.

Then we have far-ranging problems like those that are taking place in Kosovo and Yugoslavia where this government is spending large amounts of money, we have spent about $9 billion, to try to work through situations in Yugoslavia which evolve out of racial and ethnic and religious differences. Whereas I was all in favor, of course, of extending the resources of this country into that situation, I think that the Yugoslavia situation is totally out of hand. And $9 billion, more than $9 billion is enough to invest.

Our Nation is an indispensable Nation available, and I think that is important to help with trouble spots anywhere in the world. But we should not let ourselves get sucked into any trouble spot for so long that it absorbs an inordinate amount of resources and takes away the possibility of helping with other problems.

I think it was right that we went into Haiti to help liberate Haiti from people who had taken over from a duly elected democratic government. I think it was important that we went into Somalia. I think it is important that the President has shown great concern, and there are some resources now deployed in Rwanda. All of these situations, Rwanda, Somalia, Kosovo, Serbia, Bosnia, Northern Ireland. Our President did not dispense large amounts of military aid in Northern Ireland, but his own personal commitment there and the use of American diplomatic skills have helped to abate that situation.

But all over the country, all over the world, we have these conflicts based on differences and diversity. They are probably going to go on for a long, long