with the subcommittee's Senate counterpart committee, and Indonesia and East Timor will undoubtedly be a major topic at the APEC summit President Clinton will be attending this weekend.

In the wake of the historic vote in East Timor, both Indonesia and East Timor face a future filled with portent. For Indonesia, the referendum comes at a time of very sensitive political maneuvering and a fragile economic recovery.

When the subcommittee last held hearings on Indonesia on May 12, we were anxiously awaiting the June 7 national election results. Despite some violence, a very slow vote count and a limited amount of election irregularities that election was nonetheless judged by the international community to be a success. It buoyed optimism about Indonesia's ability to overcome its profound political and economic crises. However, that June election also created new complexities. No one party achieved a majority, and, in fact, the opposition, PDIP led by Megawati Sukarnoputri won a plurality of the vote. Therefore, for the first time in modern Indonesian history political coalitions will be needed to form in order to elect a new president, form a new government, carry out further economic and political reforms, address the subject of rescinding the 1976 law which integrated East Timor into Indonesia as its 27th province and address separatist sentiments in other parts of Indonesia like the province of Aceh in northern Sumatra. Indeed this is a new experience for these relatively immature political forces in a democratic Indonesia. How they carry out these responsibilities will determine the legitimacy of the new Indonesian government as viewed by the eyes of the Indonesian public and by the international community.

Of course, the most obvious and immediate task is the crisis in East Timor. After years of Indonesian intransigence, President Habibie took bold steps towards resolving this longstanding problem. In January, he seemingly brushed aside the reservations of the military and others in the Indonesian society and surprised the world by offering the people of East Timor an opportunity to determine their own future through the ballot box. Many of us were encouraged by this bold and positive development. There was perhaps a general sense of guarded optimism prompted by the assurances of President Habibie and Armed Forces Chief General Wiranto that Jakarta would maintain order and create an environment conducive for a fair and safe election, but that proved not to be a realistic assessment. Despite increasing violence and intimidation by Indonesian militarily supported militia in the recent Timorese elections, a record 98.6 percent of registered voters turned out to vote with 78 percent of them choosing independence.

The will of the East Timorese people is clear and overwhelming. It is evident by the truly horrific events in East Timor over the past week that the Indonesian government and particularly the Indonesian military has been deliberately unwilling or perhaps in some cases unable to uphold their responsibilities to provide peace and security.

It must be emphasized that this is Indonesia's responsibility. Indonesia demanded this responsibility from the United Nations, and the international community entrusted it to Indonesia. It is reported the United Nations Secretary General Kofi Annan has made very strong representations to the Indonesian government about their obligations and the negative consequences Jakarta could face from the international community for jeopardizing the integrity and the subsequent implementation of the expressed citizens' desires of this U.N.-sponsored election. The United Nations General Assembly should do the same.

Mr. Speaker, I will report more on these events after the weekend and after we complete work on a resolution that we intend to offer on a bipartisan basis early next week.

AMERICAN PEOPLE ARE RENTING THEIR CURRENCY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. METCALF) is recognized for 5 minutes.

Mr. METCALF. Mr. Speaker, I would like to talk briefly about money. Everybody is interested in money. My wife asked me: If you know so much about money, how come we do not have very much? But I would like to talk about money this evening.

Did you know that we pay rent on our money; the cash we use, we pay rent on it? It costs the American people $100 per person per year to rent our cash; that is, the paper money, from the Federal Reserve.

Now, the Federal Reserve gets the money, it just does not spend that money or keep it. They return it to the Federal Treasury. That means that the American people are paying a tax on our money in circulation for the privilege of using Federal Reserve notes. In reality, this money is paid to the Fed by the Treasury to pay the interest on the U.S. bonds that back our money.

This is a foolish system when the U.S. Treasury could issue our currency directly without debt and without interest as they issue our coins. Most people do not know that our coins are minted by the Treasury, essentially spent into circulation, and the U.S. Treasury makes a neat profit on them. But when we issue cash, we go further into debt. When the U.S. Government issues paper cash, they go further into debt because bonds are created to back the cash, and thus the debt increases.

With a currency we go into debt, but it makes a profit when coins are placed in circulation. This is truly a system that defies logic, and we should issue our coins or issue our cash as we issue our coins.

Here is a simple way to accomplish that; this is not complex, this is not rocket science. Congress only needs to pass legislation requiring the Treasury to print and issue U.S. Treasury currency in the same amount, in the same denominations, of the present Federal Reserve notes. No change in the money supply. The Treasury would issue these U.S. notes through the banks and at the same time withdrawing a like amount of Federal Reserve notes.

As these Federal Reserve notes are collected by the U.S. Treasury, they must be returned to the Federal Reserve and essentially to redeem the over $400 billion of U.S. interest bearing U.S. Treasury bonds now held by the Fed. So the Fed holds the bonds. We can take the U.S. currency and exchange it for those bonds. Over a couple of years we will have U.S. currency circulating instead of Federal Reserve notes, and the U.S. debt would be reduced by over $400 billion.

That sounds too simple. Well, it is simple. This is not rocket science. There is no appreciable down side, and I expect to discuss this issue a lot in the future just because somebody needs to take a look at how our money was issued and allow us to avoid paying that $27 billion a year interest just to rent our currency from the Federal Reserve.

HMO REFORM UPPERMOST ON MINDS OF AMERICANS

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

Mr. PALLONE. Mr. Speaker, the issue of HMO reform has become one of the most important issues on the minds of Americans today, and I can certainly tell you that from the forums and the people that I met and talked to during the August break that we recently held with the House of Representatives. I had a number of forums in my district that were specifically about HMO reform where we talked about the Patients' Bill of Rights and what some of us are trying to do in the House of Representatives to reform HMOs and to end some of the abuses. And I found overwhelmingly that at my general forums or my forums that were specific to HMO reform that people felt that the need to address the abuses of HMOs and managed care was the number one issue on the minds of my constituents. And we know that polling around the country amongst Democrats, Republicans, and Independents shows that that is certainly the case as well.

There have been also I should mention a number of front page articles in the leading newspapers, the New York Times, the Washington Post on the fevered pitch, if you will, that the debate over managed care reform has assumed on Capitol Hill, and it is also assumed

I would say a clear and identifiable framework.

The debate is now one between supporters of managed care reform on the one hand, mostly Democrats, and some Republicans and the Republican leadership on the other hand. The Republican leadership which with the insurance industry are fighting tooth and nail to undermine the various managed care reform proposals that have been introduced either by Democrats, by Republicans or on a bipartisan basis.

The issue of HMO reform has reached the dimensions it has because patients are being abused within managed care organizations. It is just common sense. Many people come up to me because they have had problems with HMOs where they felt that common sense would dictate that they should be able to go to an emergency room or they should be able to have particular treatment or stay in the hospital a few extra days, and they are told that they cannot.

Patients today 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, HMOs, the judgment of doctors is increasingly taking a back seat to the judgment of the insurance companies. Medical necessity is being shunned 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, they are in theory paying for it in their premiums.

□ 2100

I cannot emphasize enough, Mr. Speaker, how many times during the break, during the August recess, that people came into my district office complaining about abuses related to HMOs and managed care.

Now, 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. I have been on the floor many times talking about the Democrat Caucus' Health Care Task Force, which I cochair; and together with the gentleman from Michigan [Mr. DINGELL] and most Democratic Members here in the House, we have introduced legislation which would provide patients with a comprehensive set of protections from managed care abuses. This is the Patients' Bill of Rights, as it is called. It is not an attempt to destroy managed care, it is an attempt to basically improve it and to make it better.

I cannot emphasize that enough. During the forums I had during the break, I had actually people from an insurance company who sold insurance policies for managed care, and I suggested to them over and over again and explained to them that those of us who want reform are not against managed care. Managed care is here to stay. We know that it saves money; we know there are positive values to it. But on the other hand, the abuses have to be corrected.

Now, I wanted to say that what happened just before the August break in that first week of August when we were last in session was very significant. At that time and a few weeks prior to that the Republican leadership was saying they were willing to bring some kind of managed care reform to the floor and let us vote on it, up or down. However, they ultimately decided not to allow that, not to do that.

Because of that, there were Republican Members, and I will mention the two leaders, the gentleman from Georgia [Mr. NORWOOD] and the gentleman from Iowa [Mr. GANSKE], both Republicans, both health care professionals, who decided they were going to join together. Because they could not get a vote on the floor on managed care reform from the Republican leadership, they would join together and bring some of the Republican colleagues over to help most of the Democrats who had sponsored and put forward the Patients' Bill of Rights.

So just before the break, it was announced there would be a new bipartisan bill sponsored by these Members, the gentleman from Michigan [Mr. DINGELL] and the gentleman from Georgia [Mr. NORWOOD], the gentleman from Michigan [Mr. DINGELL] being our Democrat and ranking member on the Committee on Commerce, and the gentleman from Georgia [Mr. NORWOOD] and the gentleman from Iowa [Mr. GANSKE], also Republican members of the Committee on Commerce; and we would put together a new bipartisan Patients' Bill of Rights, which is very similar really to the Democratic bill that came out of our Democratic Health Care Task Force and that we as Democrats have been talking about for the last year or more, and we now have 20 Republicans who have agreed to cosponsor this new bipartisan Patients' Bill of Rights.

That was a major achievement. There are now a majority of Members of this House on both sides of the aisle that are willing to say that they want the Patients' Bill of Rights brought to the floor and are willing to cosponsor the bill.

Unfortunately, nothing has really changed in terms of the Republican leadership. The Patients' Bill of Rights, this new bipartisan one, does not enjoy the support of the Republican leadership. In fact, if we are to believe, if you will, what we read in the newspaper, it is not just the Patients' Bill of Rights that the Republican leadership opposes. They appear to be opposed to the larger notion of managed care reform. They are simply not willing to cross the insurance industry in order to give patients better protections and doctors greater power over medical choices.

I would like to point out that the GOP leadership's opposition to the new bipartisan Patients' Bill of Rights is not exclusive to the House. In the Senate, Senator NICKLES recently lambasted the American Medical Association for supporting the Patients' Bill of Rights. During the break the American Medical Association, I should mention, came out in support, unconditional support, of this new bipartisan Patients' Bill of Rights. Yet Senator NICKLES said he was shocked that they would do it, and he suggested that the AMA's support of the Patients' Bill of Rights would jeopardize their relationship with the Republican Party.

I have to point out that it is not just the AMA, it is not just the AMA representing doctors, it is almost every health care professional organization that has now come out in support of the Patients' Bill of Rights. We have over 100 patients, medical health care and consumer groups that have announced their support for the bill, and I think the problem with the GOP leadership, the Republican leadership, is that rather than hear the voices of the vast majority of their constituents and the overwhelming voices of the medical and the health care professionals and the consumer groups that say they support the Patients' Bill of Rights, instead the Republican leadership just looks to the special interests, the HMOs and insurance companies, and only hears their voices to decide what they as Republican leadership should do.

Basically what we have, now that we have come back into session, and we will be in session for most of the fall, is essentially a scene or a showdown, if you will, between the supporters of the Patients' Bill of Rights, bipartisan, and the Republican leadership. With very few legislative days left in the 106th Congress, those who support patient protection believe it is increasingly important that everyone come together and send a strong message to the GOP leadership about getting the Patients' Bill of Rights to the floor for a vote.

I would bet any money that if the Republican leadership brought the new bipartisan Patients' Bill of Rights to the floor of this House, it would pass overwhelmingly, so that is why they are not doing it, because they are afraid that would in fact happen.

But there is widespread agreement in Congress for ensuring with this bill that medical decisions are being made by doctors based on medical need and not by company bureaucrats whose primary concern is profit margin. I believe that if we continue to agitate on a bipartisan basis now to bring this bill to the floor, we will eventually have success.

Now I wanted to point out, if I could this evening, what the Republican leadership did during the break in concert with the HMOs or the insurance companies, with these special interests, to try to kill the Patients' Bill of Rights and those who might be interested in

supporting it, again, both Democrats and Republicans.

I am just reading, if I could, or making mention of an article that was in Congress Daily, which is a publication that circulates on Capitol Hill. This was an article that was in the Congress Daily during the break, Thursday, August 19.

It says: ''Insurers business target Norwood Dingell supporters.'' They are again making reference to the bipartisan bill. ''Health insurers, health plan and business groups today unveiled the advertising campaign they will target at States and House districts where members have cosponsored or are leaning towards supporting managed care reform. Health Insurance Association of America President Charles Chip Kahn said cosponsors of the bipartisan managed care bill authored by Representative Charles Norwood, Republican of Georgia, and Commerce ranking member John Dingell, Democrat of Michigan, will rue the day,'' this is a quote, ''will rue the day they decide to endorse it. During the next two weeks, the HIAA will spend $250,000 airing 60-second radio ads that will run in Buffalo, Elmira and New York City, New York, Miami and West Palm Beach, Florida, Chattanooga and Knoxville, Tennessee, Philadelphia and Casper, Wyoming, where GOP Representative Barbara Cubin is a cosponsor of the Norwood-Dingell plan. Including HIAA's advertising campaign over the next two weeks, Kahn said, health plans and business groups opposing managed care bills will spend more than $1 million working towards a cacophony of criticism of the bills. The health benefits coalition, a group of employer-based organizations opposing the managed care bills, is ramping up its spending for the last two weeks of the break, said an official with one of the groups. The coalition will launch television and heavy radio ads and heavy grassroots pressure against about 35 Republicans who either have signed or might sign on to the Norwood-Dingell plan. The ads are pretty tough and they are intended to provoke a backlash, the official said. We are going after members who are soft but gettable.''

Basically what they are doing is spending their time during the break, spending money, trying to persuade, particularly Republicans in this case, not to cosponsor the now bipartisan Patients' Bill of Rights.

It is not just this group, the HMOs. ''The American Association of Health Plans will launch a TV ad campaign aimed at 60 House Members, said spokesman John Murray. The ads will target Norwood-Dingell cosponsors as well as House Members still on the fence. Murray said, we are going to spend whatever it takes.''

How do you like that? This is the problem that we face, the money that the special interests want to spend, and they are working with the Republican leadership, even against Republican Members who feel that they want to cosponsor the Patients' Bill of Rights and are supporters of what is good for the average American. ''The business roundtable also will launch radio ads during the remainder of the August recess,'' their spokesman said.

Well, just to give you an example, it is not just during the recess. It continues this week in Congress Daily, which, again, is a publication that every Member of the House gets on a regular basis. Every day this week there has been a full page ad which was just sort of a white sheet, and in the middle of it there is this warning, like the kind of warning you would get on a cigarette package, that says, ''Warning: The Dingell-Norwood Patients' Bill of Rights could be hazardous to your health care.''

It does not really explain why. There is some fine print at the end that tries to explain why, which does not really make any sense. But this advertising campaign continues, and I have no doubt that it will continue throughout the fall and way beyond to try to target and dissuade not only Democrats, but, even more importantly, now Republicans, who want to sign on to the bipartisan Patients' Bill of Rights.

I mentioned before though and I will mention again that supporters, both Democrats and Republicans, of the Patients' Bill of Rights can take solace in the fact that the average citizen, as well as all the health care professional organizations, pretty much now are solidly behind our HMO reform.

Another thing that came out within the last month that I thought was particularly interesting was a survey that showed just how much managed care frustrates physicians and how physicians and health care professionals in general feel that they cannot really properly take care of their patients because of the abuses of managed care.

This was also in Congress Daily, and it says, talking about this new survey, that nearly 90 percent of physicians say health plans have denied their patients recommended care during the last two years, and in some cases those denials occur as often as every week.

The survey was released by the Kaiser Family Foundation and the Harvard School of Public Health. Kaiser Foundation President Drew Altman expressed surprise about the pervasiveness of problems reported between providers and insurers. ''Some tension is to be expected,'' Altman said, ''but the degree of conflict reflected in this survey suggests we are in a new world, and it is hard to argue it is good for the health care system.''

According to the survey, the most common denials were for prescription drugs. Sixty-one percent of physicians said they had a patient experience a denial weekly or monthly with regard to prescription drugs. Denial of diagnostic tests, 42 percent of patients have been denied a test weekly or monthly. Forty-two percent of the patients said that they had had some kind of denial, weekly or monthly; hospitals stays, 31 percent weekly or monthly; referrals to specialists, 29 percent weekly or monthly. This is the physicians relating what happened to their patients.

Depending on the problem, between one-third and two-thirds of physicians said a denial resulted in a somewhat or very serious decline in patients' health. So, again, we are talking about what is happening in the real world. We are talking about the abuses and the problems that people have on a regular basis.

The physicians, according to that survey, see these problems, see what is happening to their patients, and feel it is having a really negative impact on the quality and delivery of health care that people receive in this country.

□ 2115

Now, before I conclude tonight, I wanted to spend some time talking briefly about our new bipartisan approach, our new Patients' Bill of Rights, which, as I said, is supported by almost every Democrat and at least about 20 Republicans at this point, but continues to be opposed by the Republican leadership. That is why we have not been able to get it to the floor.

If I could just explain some of the commonsense proposals that are part of this new bipartisan Patients' Bill of Rights, I have a summary that basically divides it into access to care, information about care, protecting the relationship between the physician and ourselves as patients, and the basic accountability.

I will start with the issue of access to care, because I think for most people that is the biggest problem, the denial of different kinds of treatments or hospital stays or equipment that they experience.

Most important, we try to address the problem with emergency services. Individuals should be assured that if they have an emergency, those services will be covered by the plan, that they do not have to call before they can go to an emergency room if they feel that they do not have the time to do that because their health is at risk; that they do not have to go to a particular emergency room rather than the one that is closest to them because they feel that they do not have time to go to the one that is further away.

The bipartisan bill says that individuals must have access to emergency care without prior authorization in any situation that a prudent layperson would regard as an emergency. So if you as the average person think that when you have chest pains that you should be able to go to the local emergency room, the HMO cannot say you have to go further away or you need prior authorization.

Let me talk about specialty care. Patients with special conditions must have access to providers who have the requisite expertise to treat their problem. Today in this day and age people increasingly have to go to specialists

for particular problems. Increasingly what we find is that patients in HMOs have a problem getting referral to a specialist, or there is not a specialist within the HMO network who can take care of their problem.

This bipartisan bill, our bipartisan bill, allows for referrals for patients to go out of the plan's network, doctors who are not in the network, for specialty care at no extra cost if there is no appropriate provider available in the network for covered services.

Chronic care referrals. For individuals who are seriously ill or require continued care by specialists, plans under our bipartisan Patients' Bill of Rights, plans must have a process for selecting a specialist as a gatekeeper for their condition to access necessary specialty care without impediments.

In other words, if you have a chronic condition, this specialist you can go to on a regular basis, he becomes almost your primary care provider so you do not have to constantly go back to the primary care provider to continue to be able to see the specialist.

Our bipartisan bill provides direct access to OB-GYN care and services. With regard to children, the bill ensures that the special needs of children are met, including access to pediatric specialists and the ability for children to have a pediatrician as their primary care provider.

Again, continuity of care. I have found a lot of people during the break and who continue to complain to me about how if their doctor is dropped by the network, that all of a sudden they are not with the physician that they have used for a long time. Under our bipartisan bill, patients are protected against disruptions in care because we set up guidelines for the continuation of treatment in circumstances where the doctor is no longer part of the network, for example.

There are special protections for pregnancy, terminal illness, and individuals on a waiting list for surgery.

Let me also talk about the drug formularies. One of the biggest issues with regard to HMOs is that HMOs oftentimes provide for prescription drugs, which is an important part of why people sign up for an HMO, in many cases. What we are saying with our bill, with our bipartisan bill, is that prescription medication should not be one-size-fits-all. If a plan uses a drug formulary, beneficiaries must be able to access medications that are not on the formulary when the prescribing physician says that that is necessary.

Again, what we are doing is leaving this decision up to the physician because he or she is in the best position to know what is best for the patient.

Choice of plans. People want to, in certain circumstances, to be able to go outside the network and choose a physician who is not part of the HMO network. Choice is a major component of the bipartisan bill. It says that individuals can elect a point of service option when their health insurance plan does not offer access to non-network providers.

What that means is that in the beginning if you are working and your employer provides health care, the employer has to allow you to elect a point of service option, where you can go outside the doctors in the network. But you have to make that decision initially when you sign up for your health care plan, for your HMO, and you also have to pay the extra cost of going outside the network.

So again, we are not destroying the basic idea of managed care, which is that it is a closed panel network of physicians and health care providers, but we are saying this for people who want to in the beginning, they can choose the point of service option.

Those are the access issues that are primarily addressed by our bipartisan Patients' Bill of Rights, but I would like to now talk about the information issue, briefly, because many people are concerned that they do not really know what they are getting into when they sign up for an HMO.

What we say is that we require managed care plans to provide important information, and that is information that allows them to understand their health plan's policies, procedures, benefits, and other requirements.

I would like now to go into the issue of grievances and appeals, because one or really the hallmark, if you will, of the Patients' Bill of Rights and the whole effort towards Medicare reform is to make sure that the decision about what type of care you are going to get, the decision about what is medically necessary for you as a patient, is based not on what the health insurance company wants and what the health insurance plans want to cover, but rather is based on what your physician, the health care professional, thinks that you should be provided with.

So what we are basically saying, and the thread that sort of runs through the whole Patients' Bill of Rights, is that the issue of medical necessity should be decided by the physician and the patient, not by the insurance company, and that if there has been a denial of care, then that decision to appeal that denial of care and overturn it, if necessary, should be made by an independent group not appointed and not under the control of the HMO, and that ultimately you should be able to go to court if you are not satisfied, as well.

What we have in our new bipartisan bill is it basically lays out criteria for a good utilization review program, physician participation in the development of raw criteria, administration by appropriately qualified professionals, and timely decisions within 14 days for ordinary care up to 28 days if the plan requests additional information, and the ability to appeal these decisions.

So we want the health care professionals to be involved in making the decision of what kind of care you get and that there is a timely appeal if you have been denied that care by the insurance company.

There are really two processes in terms of the grievances and appeals. One is internal and one is external. Patients should be able to appeal plan decisions to deny, delay, or otherwise overrule doctor-prescribed care and have those concerns addressed in a timely manner. So we require an appeals system that is expedient, particularly in situations that threaten the life or health of the patient.

Other than the internal appeal, though, there also should be the opportunity for external review if the health care plan ultimately says no, we are not going to allow you this care. What we say is that the health care plan has to pay the cost of the external review, and that the decision by the external reviewer is binding on the health care plan.

If a plan refuses to comply with the external reviewer's determination, the patient may go to Federal court to enforce the decision. I will get a little more into that a little later, about if you are denied through the regular administrative process, that you can go to court.

Let me just talk a little bit, though, before I get to that ultimate issue of accountability, talk a little bit about how we try to protect the physician-patient relationship.

One of the things that is most shocking to my constituents is when they come in and tell me that their physician is not allowed to tell them about a particular type of medical care or treatment that the physician thinks that they should be receiving.

We call it basically the gag rule; in other words, the HMO tells the physician that he or she cannot tell the patient about a procedure that they will not cover. So if the plan will not cover a particular procedure, equipment, operation, then the physician is basically forbidden from talking about it to the patient.

That is ridiculous. Consumers should have the right to know about their treatment options. What we say in our bill is that we prohibit plans from gagging doctors and from retaliating against physicians who advocate on behalf of their patients. It basically protects the physicians in these situations from retribution. It also prevents plans from providing inappropriate incentives to physicians to limit medically necessary services so that physicians do not have a financial incentive, which they often do now with HMOs, to not recommend certain services.

With regard to physician selection, which physicians are in a plan, the insurers cannot discriminate on the basis of a license in selection of a physician. In other words, they cannot discriminate based on license, location, or patient base.

The HMOs can basically decide which doctors are going to be in the network, but if the doctor meets objective standards with regard to licensure, then

they cannot say that his particular license is not acceptable. They also cannot discriminate because of the location of the physician or the patient base of the physician.

With regard to payment of claims under our bill, health plans should operate efficiently and pay providers in a timely manner. The bill would require that claims be paid in accordance with Medicare guidelines for prompt payment, because what we have found is a lot of the HMOs do not pay the physicians. They delay payment in order to save money, or to save the interest rate.

We also have a provision for paperwork simplification in order to minimize the confusion and complicated paperwork that providers physicians face. This bill would require that the HMO industry develop a standard form for physicians to use in submitting a claim.

The last thing I wanted to mention this evening is this whole issue of accountability. The main thing that the bipartisan Patients' Bill of Rights does is to provide accountability if you have been denied care. I talked about the internal and external review, that it has to be done by a group that is not beholden to the HMO.

But I think that beyond that, there has to be the ability to go to court and sue for damages if all else has failed. I think many people realize, although a lot of my constituents still do not realize it, that under existing Federal law called ERISA, the Employee Retirement Income Security Act, State laws are basically preempted. So, therefore, if you are in an ERISA plan, which is basically a plan where your employer is self-insured, any kind of self-insured plan, which millions and millions of Americans particularly in large companies fall under these types of self-insured plans, because that is what larger employers tend to do, they fall under ERISA and Federal preemption, which means that the HMO cannot be sued.

That makes no sense. The HMOs, as we discussed this evening, are basically making medical decisions. If they make a decision about what kind of care you can receive or how long you can stay in a hospital, for example, and they make the wrong decision, then they should be held accountable. You should be able to sue them.

Our bipartisan bill would remove the ERISA preemption and allow patients to hold health plans accountable according to State laws, so if the State law allows it you would be able to sue and you are not preempted by the Federal law.

The one thing that we did do, and this was I think important and makes sense, is that the new bipartisan bill says that if a plan, if a health insurance, if an HMO complies with an external reviewer's decision, they cannot be held liable for punitive damages. So if when you go to an administrative review the decision is to deny you care and then you appeal and you go to court, the court decides that the independent review was wrong, you cannot receive punitive damages, because in that case the HMO did in fact act in good faith and go to the external review process.

□ 2130

The other thing I wanted to mention because I know that part of the criticism, if you will, that the insurance companies are making in their advertisement about the Patients' Bill of Rights, they say that employers can be sued, and that because employers can be sued, then a lot of employers will simply not cover their employees; and the number of people who have health insurance will decline because of the Patients' Bill of Rights.

Well, I want to explain and emphatically state that the Patients' Bill of Rights, the bipartisan Patients' Bill of Rights, which I have been discussing tonight, does not in any way create liability for the employer.

In the bill, we have a provision that protects employers from liability when they were not involved in the treatment decision. It explicitly states that discretionary authority does not include a decision about what benefits to include in the plan, a decision not to address a case while an external appeal is pending, or a decision to provide an extra contractual benefit.

What that essentially translates to mean is that there is nothing in our bill that would in any way extend the liability of the employer and allow them to be sued because of the denial of care other than whatever the existing law is right now.

I wanted to mention one more thing before I close, and that is what we constantly get from the Republican leadership in opposing the Patients' Bill of Rights, the bipartisan Patients' Bill of Rights, and what we constantly get from the insurance companies and the HMOs in their attacks and their ads and their multimillion dollar campaign against the Patients' Bill of Rights, I think could be basically summed up in what the Health Insurance Association of America put in sort of the fine print in this ad that was in Congress Daily that I mentioned before.

It says that ''the Patients' Bill of Rights currently being considered will cause us a lot of unpleasant side effects, more red tape and more regulations that the patients can expect, and patients will end up paying the bill. Health care costs would increase.''

They basically stress the fact that what we will see with this Patients' Bill of Rights is a huge increase of costs and that that will make it more difficult for both individual as well as employers to provide health insurance. Nothing can be further from the truth.

The reality is probably best summed up by making reference to the State of Texas. About 2 years ago, the State of Texas passed a law that has been in effect, I should say, for about 2 years, which is very similar to the bipartisan Patients' Bill of Rights that I have been advocating tonight.

As a result of that Texas law which allowed people to bring suit, the number of lawsuits that have actually been brought within the last month, over that 2-year period, only two lawsuits have been brought because of the change in the Texas law that provides patient protections.

In addition to that, it was estimated that the premiums have gone up about 30 cents a month during the 2-year period that the Texas patient protections have been in effect. That 30-cent increase could have occurred because of inflation or whatever, but the bottom line is it is insignificant. Any consumer, any constituent of mine would gladly pay an extra 30 cents a month to have the kind of protections that are in place here.

I think that in their advertising campaign the HMOs said that health care costs could increase as much as $200 per family, forcing small employers to drop their health insurance all together. The Texas experience shows very emphatically that that is simply not true. There really is not any significant added cost, because what the Patients' Bill of Rights does is to provide for prevention.

Now that the HMOs cannot allow the kind of abuses now that they are threatened with the right to sue and the external review, they take the proper precautions; and lawsuits don't occur, and costs really do not go up significantly.

So I am going to end this evening, Mr. Speaker, but I wanted to point out that the new session has begun. The fall session has begun. Those of us who advocate the Patients' Bill of Rights are going to be out there on a daily basis saying that we want the Republican leadership to bring this bill to the floor.

We have a majority of Members of the House that now support us. Most of the Democrats. At least 20 Republicans. I think the number of Republicans are going to continue to rise, because they realize, Members of this House realize in a bipartisan basis that this kind of reform is needed.

I am just calling again on the Republican leadership and will continue to call on them to allow this bill to come to the floor. If it does, we will pass it overwhelmingly, and we will finally see protections within the context of HMOs that Americans are crying out for.

TRIBUTE TO THE HEROES OF THE GRAND JUNCTION SHOOTING

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

Mr. MCINNIS. Mr. Speaker, as many of you know, my district is in the