not have that. So we have a real document against just rhetoric, and it is making for an unbalanced debate.

I think if we can get the Members at the other end of this building, as well as the gentleman at the other end of Pennsylvania Avenue in the White House, to in fact give us some documents, we would have the basis about which we could sit in a room and combine them and merge them and work out the differences, as we do regularly and is our job.

I yield to the gentleman from North Carolina.

Mr. BURR of North Carolina. As the gentleman from Pennsylvania knows, it is one thing to talk about catastrophic coverage, which is the ability to look at the senior population and say the one thing that we can do is put the Federal Government where it should have been in health care, the safety net, and assure our seniors that if they ever spend out of pocket a certain amount of money in a given year that they will never be exposed for any more than a fixed amount, catastrophic coverage, a limit. It is one thing to talk about it; it is another thing to put it on paper and to pass the test of the Congressional Budget Office or the Office of Management and Budget and have that number scored. But we did it. We did it and we lived within the framework of the available money, and we provided a stop loss for seniors of $6,000.

The President had a bunch of pieces of a plan, and he said he would like to incorporate stop loss or catastrophic loss, but the fact is that he could never do it in a way that he could put it on paper and have that paper scored because of the way he proposed designing the original plan, which was no choice, which got very little discount from the current price of pharmaceuticals in the marketplace.

The Congressional Budget Office looked at our approach and said that because we had competition, because we had provided seniors and the disabled choice in the plans that they could choose from, we will achieve at least a 25 percent discount across the board for things that are insurance-based purchased and for things that are purchased out of pocket, a 25 percent savings just by creating choice that the administration does not get with their proposal.

Mr. GREENWOOD. And if I may, that is before we even apply the Federal contribution to the actual price of the item. So that 75 is cut in half. And, of course, we pay 100 percent of the remainder for the low-income and for middle-class folks, a half. So now we are talking about going from paying 100 percent of retail price to paying 37½ percent of retail price. It is almost a two-thirds reduction in the cost of the pharmaceutical product to the average American.

Mr. BURR of North Carolina. If there existed truth in advertising on this we would have stars all across this plan because it provides at every level what seniors want.

Before the gentleman mentioned employers, I had written the word employers on a piece of paper up here because that was one of the biggest challenges that our whole task force had. There is a segment of America, a large percentage of America that are seniors today that are currently provided prescription drugs as a benefit of their retirement. As we see prices go up 11 or 12 percent a year, the question we have to look out and ask is how long will they continue to offer that benefit. Because they are not obligated to, it is just a commitment that they made when individuals retired.

We found a way to incorporate into our plan that those employers that provide that benefit, once those individuals reached that stop-loss amount, they would be covered under the Federal stop loss, a great incentive for employers to continue to provide that first dollar coverage for the millions of seniors that are currently under their health plans. We found the approach to keep the employer engaged.

We found a way to incorporate the catastrophic or the stop loss into their plan without dislocating them, which made our plan totally voluntary to every eligible person regardless of where they currently had their coverage, if they did. They could stick with that and still utilize that stop-loss protection of the national plan.

Clearly, we spent a lot of time on that, making sure that we got it right. But the fact that it was voluntary, the fact that for those that chose to participate there was choice, the fact that everybody, whether they were in their employer plan or chose one of the accredited plans by that new entity that ran the prescription drug benefit, all of them benefited from an annual stop-loss amount that protected every senior and made sure that they could not lose everything that they had accumulated because they had run into a health care problem that required unusual pharmaceutical costs.

Mr. GREENWOOD. I believe our time has just about elapsed. I want to thank the gentleman from North Carolina for his participation, as well as my other colleagues from around the country.

This clearly is, if not the number one issue in America, certainly ought to be. There is still time to resolve this issue. All we need to do is to work with the House and the Senate and the President together and, in fact, we can all be proud of meeting a need that just cries out to be met; and we think we have made a good start.

ANNOUNCEMENT OF INTENTION TO OFFER MOTION TO INSTRUCT CONFEREES ON H.R. 4205, FLOYD D. SPENCE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2001

Mr. SCARBOROUGH (during the Special Order of Mr. GREENWOOD). Mr. Speaker, pursuant to clause 7 (c) of rule XXII, I hereby announce my intention to offer a motion to instruct conferees on H.R. 4205 tomorrow. The form of the motion is as follows:

> I move that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the bill (H.R. 4205) be instructed to recede to the Senate language contained in section 701 of the Senate amendment to H.R. 4205.

The SPEAKER pro tempore (Mr. PEASE). The notice of the gentleman from Florida will appear at the appropriate place in the RECORD.

HEALTH CARE ISSUES

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

Mr. GANSKE. Mr. Speaker, I am going to speak on several issues related to health care this afternoon. As my colleagues know, before I came to Congress I was a physician practicing in Des Moines, Iowa. I do have some insight into some of these health care issues that we are trying to tie up before the end of this session, whenever that will happen.

Let me first speak about the prescription drug problem. I just finished a series of town hall meetings around my district.

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I will tell my colleagues that the high cost of prescription drugs is a real one, not just for senior citizens but for everyone, and it is a major component to the increased premiums that we are seeing for working families in terms of their health insurance premiums. Prescription drug costs for those health plans are going up 18 to 20 percent per year, and then those costs are being transferred on to the businesses that pay for health insurance and then on to increased premiums for the family. So it is not senior citizens. But from my town hall meetings, I had a senior citizen in Council Bluffs come up to me and tell me that between his wife's drug costs and his drug costs, they were spending almost $13,000 a year on prescription drugs. They were by no means a wealthy family. I had another gentleman in Atlantic, Iowa come up to me and he had a whole packet of his prescription drug costs. They amounted to almost $7,000 a year.

Now, it is true there is a certain percentage of senior citizens who are fortunate, who are healthy, who do not have any drug costs. That is about 14 percent of the Medicare population. And about 36 percent have less than $500 out of pocket. But there is a group of senior citizens that have very high drug costs. We need to address that problem.

As a Republican, I just have to offer a polite voice of dissent, because the plan that passed this House is simply not going to work. It relies heavily on

insurance companies to offer prescription drug policies. I sit on the committee of jurisdiction, the Committee on Commerce, the Subcommittee on Health and Environment. We had testimony before my committee by the insurance industry that said, we will not offer those types of policies. They have a pretty good reason for doing that: They cannot predict what the future costs of the prescription drugs are going to be. They are afraid that they will get locked into a program at a certain rate, see their costs rise way above that and they simply repeatedly, to both the House and the Senate, have said, ''We're just not going to offer those plans.'' So it does not do you any good to pass a bill on the floor of the House that relies on insurance companies to do that when they say from their past experience and their present experience that they are not going to do it.

What is the solution? Well, I have a bill before Congress that has several important points, but two of them I think are very important: One is for that senior citizen who is right on the margin of being in poverty but is not in Medicaid as well as Medicare, we ought to do something to help that senior citizen with their high prescription drug costs. We could do that simply, not by creating a new bureaucracy. There already is a program in place for poor senior citizens and that is the Medicaid program. Every State has a Medicaid program for those senior citizens who are below the poverty line. And every Medicaid program that I know of has a drug benefit.

And just about every State that I know of has negotiated discounts with the pharmaceutical companies for those drug programs. So we ought to look at including those senior citizens who are above that poverty line, maybe up to 175 percent of poverty and include them in that Medicaid drug benefit. No new bureaucracy, they simply get a card. We could pay for that from the Federal side so that we would not be talking about an unfunded mandate on the States. It would be significantly less expensive than what we are talking about with the other proposals and we could get it done today. We could implement it tomorrow. Yes, it would not be comprehensive for everyone but it would certainly help those who need it the most in Medicare.

But what could we do for everyone?

The second thing that we should do to help with the high cost of prescription drugs, not just for senior citizens but for everybody is to readdress a law that Congress passed in 1980. It was signed into law by President Reagan, but he did so with grave reservations. He was concerned that that law would generally prohibit certain types of beneficial competition in the sale of pharmaceuticals by hospitals and other health care providers that would allow consumers to benefit through increased choices and lower prices. What was that bill? It was a bill that gave the pharmaceutical industry special protection, something that, as far as I know, no other industry in this country has and, that is, that you cannot reimport into the United States drugs that are made in the United States and packaged in the United States. It is against the law. Anyone who does that, brings drugs across the border, prescription drugs, could be prosecuted, fined. Senior citizens who have done this have gotten very nasty, threatening letters from the Customs Service or from the Food and Drug Administration. Even though senior citizens do cross to Mexico and do cross to Canada and do buy prescription drugs, they are breaking the law.

I got a letter the other day from a senior citizen in Des Moines, Iowa. He is a volunteer at a hospital that I used to work at, and he participated in a drug study at the University of Iowa for an arthritis medicine called Celebrex. That medicine worked really well for him. So he went to his doctor, he got a prescription, he went to the hospital where he is a volunteer, went to the pharmacy there and with a volunteer discount could get that prescription for about $2.50 a pill. Well, this gentleman is a pretty smart guy. He got on the Internet that night and he found out that he could, with about $10 or $15 of shipping and handling, get that prescription from Canada from a pharmacy for about half price. Same thing from a pharmacy in Geneva, Switzerland. And from Mexico he could get that medicine for about 55 cents per pill, made in the United States, packaged in the United States.

Look at this chart. Here are some drugs with a U.S. price and a European price. Let us say Coumadin, that is a blood thinner medicine, twenty-five 10-milligram pills in the United States will cost you $30.25. Over in Europe, $2.85. From $30 to $3. How about Prilosec? Twenty 28-milligram pills in the United States, $109. In Europe, $39.25.

How about Claritin? Claritin is a good antihistamine. It is advertised night and day. I guarantee my colleagues that if they watch any TV or look at any billboard, they are going to see Claritin advertised. The marketing budget by the company that makes this is astronomical. Why? Because they are making a ton of money on it. They are also trying to get an extension of their patent, which this Congress should oppose. But Claritin. For 20 pills in the United States, $44. In Europe, and this is not a Third World country. In Europe, $8.75.

I can go down this whole list. This is just representative of the difference in the cost between what we pay in the United States and what they pay in Canada or Europe, not to mention in Mexico. Why is there such a differential? Because there is not any competition, any global competition. We are subsidizing the high profits of the pharmaceutical companies in this country because of that law. Changing that law to allow a reimportation of those medicines is part of my bill. But I have to tell you that others have been involved in this issue, also. The gentleman from Oklahoma (Mr. COBURN), who is a physician; also, the gentleman from Maine (Mr. BALDACCI); Senator JIM JEFFORDS, and several others have been interested in this. We have now passed amendments to appropriations bills that would overturn that law that prevents prescription drugs from being reimported back into the United States.

In the House, we had a vote. We had a vote in the House that was 370–12 in favor of doing that. There was a vote in the Senate that was 74–21 to overturn that law. 370–12 in the House; 74–21 in the Senate. Why? Because I think intuitively we realize that if we could get in on a 1–800 telephone number or get on the Internet and be able to order our prescriptions filled from Canada or from Europe at a lower price, we know what would happen to the prices in the United States. In order to be competitive, they would come down.

Every farmer in my district knows what the price of soybeans is and they know that that price is determined by the world market. But on prescription drugs, we have given the pharmaceutical companies a special interest protection. That should be changed. If we allow competition on a global basis, the prices will come down. They will come down for everyone, not just senior citizens. They will come down for the businesses that are providing the health insurance to their employees. The pharmaceutical companies have profit margins that are three and four times higher than any other group of companies in the country. Believe me, they will still make plenty of money if we introduce some competition. And that is not setting any prices. That is not a government price-setting mechanism. That is simply allowing the market to work.

My friends on the Republican side of the aisle, all of them who voted for this, who believe in free markets and that free markets and competition bring down prices, they and all of our colleagues on the Democratic side who voted for this bill should insist with such support from both the House and the Senate that those amendments not be stripped from the conference bills on those appropriation bills that come back for our vote.

The pharmaceutical companies are lobbying night and day to get those provisions removed. If the leadership of the House or the leadership of the Senate accedes to the pharmaceutical companies' desires and strips out provisions where overwhelming majorities in both the House and the Senate have expressed their will, we are not talking about a narrow vote margin, we are talking about a margin where only 12 Members in this House voted against that, where only 21 Members in the Senate voted against that provision. If the leadership in the House, the Republican leadership in the House and the

Republican leadership in the Senate strip those amendments out of those appropriations bills, then every American in this country who is paying a high prescription drug cost will know where part of the problem lies.

This is not a time to bow to special interests, big corporate, soft dollar contributions.

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This is a time to stand up for every American who is paying outrageously high drug costs compared to the rest of the world. To buy a very simple remedy, bring down the costs of prescription drugs for everyone. If the conference bills come back, one of them is the agricultural appropriations bill, if that comes back with this provisions stripped out, I can grant my colleagues that I will be here on the floor, the gentleman from Oklahoma (Mr. COBURN) will be here on the floor, the gentleman from Maine (Mr. BALDACCI) will be here on the floor.

We will be pointing out to all of our colleagues that the leadership in this House and the leadership in the Senate, which is giving directions to that conference committee, is trying to subvert the overwhelming Democratic majority, the overwhelming majority of both Republicans and Democrats on a very, very important policy issue.

That is something we can get done. The administration, the Secretary of Health and Human Services, Donna Shalala, has said we can agree to that provision; we think we might need a little more money to make sure that the Food and Drug Administration can oversee, to make sure that there is not a problem with those reimported drugs.

The last figure I saw from Secretary Shalala was that her estimate was that maybe this would cost an additional $24 million in appropriations to the Food and Drug Administration. I tell my colleagues that is a drop in the bucket compared to the billions and billions of dollars that American citizens could save if we remove that special protection and let the price of prescription drugs come down because of competition.

My constituents back in Iowa who have those high drug prices will be watching to see what happens. I will be doing what I can, just like I am in this speech, to try to make sure that the will of the House and the will of the Senate is not contravened by a small minority of leadership subverting the will of the House and the Senate.

Now, let me talk about another very, very important issue that is coming up. We are going to be dealing with a bill very shortly, maybe as soon as next week, that will provide additional funding for Medicare. In 1997, we passed a bill involving Medicare, the Balanced Budget Act of 1997. Back in 1995 and 1996, I was one of the first Republicans to say be careful, do not cut those programs too much or we could see some real hurt.

At a committee hearing, I said, you know what, we are looking at deficits; but we have to be careful with that tourniquet. A tourniquet can stop bleeding, can keep a patient from bleeding to death; but if we put that tourniquet on too tight, it can cause the loss of blood supply to the extremity, and we can end up with gangrene.

We have found that there have been more savings from that 1997 Budget Act than we anticipated, and the consequences for certain groups that are involved with Medicare have been more than we planned for. And so I think it is entirely appropriate that we use part of our surplus, projected surplus, to go back in and fix some of that.

I have hospitals in my district in small towns in rural Iowa where the hospitals are right on the margin. They take care of very high percentages of Medicare patients, so they rely very much on the reimbursement that they get from Medicare; and they do not have, you know, a large population base to try to make that up with, say, charitable donations. We need to go back and give those hospitals some help.

One of the areas that they are having problems with is in keeping their nurses, because the funding formula for rural hospitals, they get paid less as a price index for their nurses than a hospital, for instance, in a metropolitan area, like Des Moines or Chicago or Minneapolis or Omaha; and so those areas can offer nurses significantly higher salaries, and they tend to just pull those nurses out of those small town hospitals.

We need to significantly re-adjust the pay scale index for those hospitals to bring up the funding so that they are providing their nurses with a competitive salary so that they will stay and help take care of those patients in those hospitals in the rural areas; otherwise, those hospitals are not going to make it.

If a small town does not have a hospital, we cannot keep our doctors there; and if we do not have doctors and if we do not have a hospital, we cannot keep our businesses there.

We are talking not only about whether patients would have to travel 80 miles or 100 miles to take care of a heart attack or to deliver a baby, we are talking about whether that community stays viable economically, continues to survive. So this is important. We need to do that.

I am troubled by what I am hearing on what the funding is going to be for this sort of emergency Medicare giveback bill, because the HMOs have been lobbying to get a huge percentage of this instead of getting it to those rural hospitals or to the teaching hospitals or to the inner city hospitals that take care of a lot of indigent parents or to other areas that need it. The HMOs want to take the majority of this, and I have a real problem with that.

I will tell my colleagues why a GAO, a General Accounting Office, report just published in August shows that the HMO program in Medicare has not been successful in achieving Medicare savings. It is called Medicare+Choice. And Medicare+Choice plans attracted a disproportionate selection of healthier and less expensive beneficiaries relative to the traditional fee-for-service Medicare program. That is called favorable selection.

Consequently, in 1998, the GAO estimates that the Medicare program spent about $3.2 billion, or 13.2 percent, more on health plan employees in HMOs than if they had received the same services through traditional fee-for-service Medicare. And, yet, I am hearing from my colleagues, oh, we have to give so much more money to the Medicare HMOs.

This is about the fourth study that we have had from either the Inspector General's office or the General Accounting Office that has shown that the average Medicare patient in a Medicare HMO costs the Medicare HMO less than what a fee-for-service patient would. Consequently, they make a lot of money off of it.

Then we had another report that came out, not too long ago, by the Inspector General's office. This was in February. What did they find? Here is the headline there from USA Today: ''Medicare HMO hit for lavish spending.'' One insurer, one Medicare HMO spent $250,000 on food, gifts and alcoholic beverages; four HMOs spent $106,000 for sporting events and theater tickets and another leased a luxury box at a sports arena for $25,000. Customers, insurance brokers, and employees at one HMO were treated to $37,303 in wine, flowers, and other gifts.

As the Inspector General said, the administrative costs for some Medicare managed care plans are clearly exorbitant. Why did they say that? Well, because they found in the study that some Medicare HMOs are doing an okay job. They are spending as little as 3 percent administrative overhead on their plans.

I do not mean to say that all Medicare HMOs are the bad guys, but other Medicare HMOs were spending up to 32 percent on administrative overhead. Think of that, 10 times the amount on administrative overhead. I guess that takes into account why some of these Medicare HMOs are buying luxury sports boxes in sports arenas, or why some of them are giving away expensive gifts on wine and flowers and other gifts and others are literally funding big parties for their employees. That is all money that should be going for patient care, not for the fat of the Medicare HMO.

And so my suggestion would be that, you know what, we ought to be very careful about providing additional dollars to those Medicare HMOs. We ought to use that money to get back directly to the people who are taking care of those patients. Yes, maybe some of these Medicare HMOs with the low administrative overheads do need some help, but I would be very careful about

throwing $6 billion or $7 billion or $8 billion at them with the type of record that they have. And we know adverse selection is when they are treating a healthier population at a lower cost.

We know from past studies in the past few years that when a Medicare HMO patient leaves an HMO, a Medicare HMO, and goes back into the fee-for-service, that it costs the fee-for-service plan significantly more than what the average Medicare HMO patient costs.

What is happening? Well, the Medicare HMOs are just fine for people who are healthier who do not have a problem, who do not need to see a particular doctor; but when a patient gets sick, then they transfer back to the fee-for-service side because they have more choice, they can get better treatment, and then that transfers a sicker patient back into the fee-for-service but keeps a healthier group for those Medicare HMOs.

I will tell you what, I am going to shine the light on this problem when this bill comes to the floor, unless we have a reasonable funding level for those Medicare+Choice plans and unless we provide the type of help we need for groups like our rural hospitals.

Now, let me briefly talk about HMOs. Last week I saw in USA Today on the front page one of those little charts that they have. This was from a Gallup poll on the confidence that the public has in certain institutions. At the top was the military: 64 percent of the public feel that they have confidence in the military as an institution; 56 percent, organized religion; 47 percent, the Supreme Court. Congress is down there at 24 percent.

HMOs are at the very bottom. Only 16 percent of the public think that HMOs are worthy of confidence or only 16 percent of the public have trust in HMOs as an institution. That is reflected, as it so frequently, in jokes and cartoons that we will see.

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Here is a cartoon. It says, remember the old days when we took refresher courses in medical procedures? And this is at the HMO medical school. And it says here, and I know that it is hard for colleagues to see this from the back, it says, course directory, first floor, basic bookkeeping and accounting; second floor, this is all at the HMO medical school, second floor, advanced bookkeeping and accounting; and third floor, graduate bookkeeping and accounting.

This is a cartoon Non Sequitur by Wiley. This is HMO bedside manner. Here we have a patient that is in traction, IVs running, being monitored, probably has some endotracheal tube, and there is a sign above his bed: Time is money; bed space is loss; turnover is profit. Remember, this is the bedside HMO manner.

Here is a health care provider saying, after consulting my colleagues in accounting, we have concluded you are not well enough. Now you can go home. That is the HMO bedside manner.

Here we have the maternity hospital. Remember this from a few years ago, the advisory group to the HMOs, a company called Milliman & Robertson, that sets up guidelines, quote/unquote for care, they said at that time, you know what, we do not think women need to stay in the hospital after they deliver babies. They can go home. So here is the maternity hospital with the drive-thru window. Now only six minutes, six-minute stays for new moms, and the person at the window, it is almost like a McDonalds, says congratulations, would you like fries with that? And there is the frazzled mom who has just delivered the baby, and down in the corner you have a little figure saying, looking a little like that scalding coffee situation.

Now this is one of my favorites because when I was in practice I was a surgeon, and so here we have the doctor standing and next to him in the operating room is the HMO bean counter. The doctor says, scalpel. HMO bean counter says, pocket knife. The doctor says, suture. HMO bean counter says, Band-Aid. The doctor says, let us get him to the intensive care unit. The bean counter says, call a cab.

Remember, these are all cartoons that have appeared in daily newspapers. This gives you an index of where the public is on this. These are grounded in reality because they would not be funny if there were not an element of truth to these.

Here is one, the HMO claims department. We have an HMO reviewer at the telephone there, says, No, we do not authorize that specialist. Over there she says, No, we do not cover that operation. As she looks at her nails, she says, No, we do not pay for that medication. Then apparently the patient must have said something rather startling and she says, No, we do not consider this assisted suicide.

And here we have an HMO doctor saying, Your best option is cremation, $359 fully covered. And the patient is saying, This is one of those HMO gag rules, is it not, doctor?

Five years ago, I had a bill in Congress, a bipartisan bill with over 300 bipartisan Republican and Democratic congressmen as co-sponsors, called the Patient Right to Know Act, which would ban gag clauses that HMOs were imposing on physicians where they said before you can tell a patient about their treatment options you first have to get an okay from us.

Think about that. There I am, as a physician, a woman comes in to me, she has a lump in her breast, I took her history, her physical exam and before I can explain her three treatment options to her, if I have a contract with an HMO like that, I have to say, excuse me, I have to go out, get on the phone and say, I have Mrs. So and So with a breast lump and she has three options; can I tell her about that? Oh, for heaven's sakes, you know what, with 300-plus bipartisan cosponsors I could not get the leadership of this House to bring that to the floor. Can you imagine that?

Well, here is another cartoon of a doctor sitting at the desk and he is saying to the patient sitting there, I will have to check my contract before I answer that question. The same thing on the gag rules.

Now this is a little bit black in terms of humor. Here we have an HMO reviewer on the telephone saying Cuddly care HMO, how can I help you? She then says, You are at the emergency room and your husband needs approval for treatment? He is gasping, writhing, eyes rolled back in his head. Hum, does not sound all that serious to me. Clutching his throat? Turning purple? Uhm hum.

She says down here, Well, have you tried an inhaler? The next panel, He is dead? Next to the last panel, Well, then he certainly does not need treatment, does he? And finally, the HMO reviewer says, Gee, people are always trying to rip us off.

Here is another one? Patient is saying, Do you make more money if you give patients less care? The doctor says, That is absurd, crazy, delusional. The patient says, Are you saying I am paranoid? The HMO, Yes, but we can treat it in three visits.

I mean, this general perception by the public based on true cases that you read about in newspapers or that you talk to your friends about at work or, heaven forbid, that your own family has had problems with in terms of getting HMOs to authorize and provide needed and necessary medical treatment is so pervasive that we are even seeing jokes about it made in movies.

Remember a few years ago the movie, As Good as It Gets, where you had Helen Hunt and Jack Nicholson, and Helen Hunt was explaining that her son had asthma but that her HMO would not provide the necessary care for him and she described that HMO in expletives that I really cannot use on the floor of Congress. I was sitting in an audience in Des Moines, Iowa, with my wife and I saw something I never saw before. People stood up and started cheering and clapping when they described that HMO in those terms. That does not happen unless there are real problems.

Well, in October of 1999, almost a year ago, here on the floor of the House of Representatives, we had a 3-day debate and a bill drafted by the gentleman from Georgia (Mr. NORWOOD), very conservative Republican; myself, a Republican from Iowa; and the gentleman from Michigan (Mr. DINGELL), a Democrat, the Norwood-Dingell-Ganske Bipartisan Consensus Managed Care Reform Act, passed this House with 275 bipartisan votes. Despite opposition from the Republican leadership, despite intensive, $100 million lobbying against it by the HMO industry, an amazing thing happened that day when

we had a vote. A large number of Members on this floor said I am going to do what is right. I am not going to listen to that special interest group. My constituents back home are telling me we need some real patient protections. We need to prevent injuries and deaths that are being caused by HMOs and, furthermore, we need to make sure that those HMOs are responsible for their actions, because under a 25-year-old Federal law, if you get your insurance from your employer and your employer's HMO causes you to lose both hands and both feet negligently or negligently causes you to die, under that 25-year-old Federal law they are liable for the cost of the treatment, period. They would be liable for the cost of your amputations and in the case of the dead patient they would not have to pay anything because the patient is dead.

I mean, is that right? Is that justice? Is there any other industry in this country that has that type of legal protection? I do not think so.

Furthermore, the public does not like that because by a margin of about 75 percent, across both party lines, across all demographic groups, people think that at the end of the day a health insurance company should be responsible for its decisions if they make a negligent decision that results in an injury. I mean, we would not give that type of legal protection to an automobile industry.

We are holding hearings right now in my committee on the Bridgestone/Firestone tire problem. I do not see anyone proposing that we give legal immunity to those companies and yet for an industry that is making life and death decisions about your health care every day, there is a 25-year-old Federal law that says you are not liable for anything except the cost of care denied. That is not right. It needs to be fixed.

Well, as I said, it has been almost one year since the House passed the Norwood-Dingell-Ganske Bipartisan Consensus Managed Care Reform Act. The Senate passed a bill, which I would charitably characterize as the HMO Protection Act. It actually put into statutory language additional protections for HMOs, not for patients. When that happens in Congress, when the House passes a bill and when the Senate passes a bill, and they differ, then they go to what is called a conference committee. That is made up usually of the people who wrote the bills and are involved with the passage. However, in this situation, because the gentleman from Georgia (Mr. NORWOOD) and I defied the House leadership, the Speaker of the House did not even name to the conference committee the two Republican Members who wrote the bill, that wrote the bill that passed the House with 275 votes.

In fact, out of the 15 or 16 House Republican Members that were named to the conference committee, only one had actually voted for the bill that passed the House, the real Patient Protection Act, and many who were appointed were adamantly opposed to it. Now, I say what message does that send? Does that send a message that the leadership in Congress really wants to get a bona fide patient bill of rights passed? I do not think so. Well, needless to say, the conferees from the Senate, they were not that interested in really getting something done, either. So the conference has failed. In fact, the conference has not met for months and patients continue to be harmed by arbitrary and capricious HMO denials of care that are costing people their health and in some cases their lives.

So in an effort to get patient protection legislation signed into law, the gentleman from Georgia (Mr. NORWOOD), the gentleman from Michigan (Mr. DINGELL), myself, Senator KENNEDY, we have created a new discussion draft of the House-passed bill seeking compromise with the Nickels amendment in the Senate, and we incorporated some of the ideas of the House substitute bills last year. We continue to think that the original Norwood-Dingell-Ganske bill is just fine, but we are willing to be flexible in order to get along.

We and the American Medical Association and over 300 health care groups who supported last year's House-passed bill have developed a discussion draft if it helps bring Republican Senators on board. We have had positive responses from a number of Republican Senators, other than those who have previously voted for the House-passed bill.

We remain optimistic that there is still time in this short time frame yet where we can break this logjam. All it takes is one or two more Republican Senators to say I think this compromise language is good language.

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We have looked at a number of ways to seek the middle. We are giving Republican Senators an opportunity who truly want to pass patient protection legislation and see it signed into law, we are giving them an opportunity to come on board to a new bill, not one that they have voted against in the past.

This discussion draft includes many of the protections nearly all the parties agree to, including the right to choose your own doctor; protections against gag clauses; access to specialists, such as pediatricians and ob-gyns; access to emergency care; and access to plan information. This discussion draft applies the patient protections to all plans, including ERISA plans, those employer health plans, non-Federal governmental plans, and those covering individuals, so that we cover 190 million Americans.

The new draft addresses the concerns of those who want to protect States' rights by allowing States to demonstrate that their insurance laws are at least substantially equivalent to the new Federal standards, thereby leaving the State law in effect. State officials could enforce the patient protections of State law. The Secretary of Labor and Health and Human Services can approve the State plan or could challenge it, if it is inadequate. Under the new draft, doctors would make the medical decisions involving medical necessity. When a plan denies coverage, the patient has the ability to pursue an independent review of the decision from a panel of physicians that is independent of the HMO. That external review would be binding on the plan.

So let us say that an HMO says to someone, your father in this HMO does not really need to be in the hospital because he says he is going to commit suicide. And the doctor says, oh, yes, he does. And the health plan says, no, he does not. We are not going to pay for any more, out the door. Let us say then your dad goes home, and he drinks a gallon of antifreeze and he dies. Under our bill, that plan would be liable for that, that health plan would be liable. That is a hypothetical situation. That actually occurred in Texas. Texas passed a strong patient protection bill. Our bill in the House was modeled after that Texas bill.

We should take the lead of the Nation's courts with particular attention given to the recent Supreme Court case, Pegram v. Hedrick. And our new draft reflects that emerging judicial consensus. Recent court decisions have suggested injured patients can hold their health plans accountable in State court in disputes over the quality of medical care, those involving medical necessity decisions. However, patients would have to hold health plans accountable in Federal court if they wanted to challenge an administrative decision, something that would deny benefits or coverage or any decision not involving medical necessity. That is in our bill, and that is an important compromise.

In addition to specific legislative provisions, our discussion draft answers continuing questions about the original bill that passed this House. For instance, our draft says, employers may not be held liable unless they ''directly participate'' in a decision to deny benefits, as a result of which a patient is killed or injured.

So, for the average business out there that simply hires an HMO to provide health care coverage for both the employer and the employees, there is no liability involved, unless the employer or the business was directly involved or directly participated in the decision, but that is not how it happens. The HMO makes the decision. The business does not.

Explicitly in our bill, the employer would not be liable for that. I cannot tell my colleagues how many times I have seen ads in the Washington newspaper, I read about radio and television ads by the groups that are trying to defeat our bill, that simply do not tell the truth on our protections for employers. I simply have to say, read the bill, read the language. Those protections for businesses are real, unless

they directly participate in the decision. Even then, defendants could not be required to pay punitive damages unless they showed a willful and wanton disregard for the rights or safety of the patients.

Another concern about our bill was whether it would affect the ability of health plans to maintain uniformity in different States. Some of the businesses that have business in many different States were concerned about this. Our new draft only subjects plans to State law when they make medical decisions that result in harm. So it does not affect the ability of a business to offer a uniform benefits package and be outside of State law as it relates to that benefits package.

This discussion draft that we have will allow Republican Senators who have voted against the Norwood-Dingell-Ganske bill to vote for a real patient protection bill. I sincerely hope that they take that opportunity. It would make a tremendously positive difference for our country. Mr. Speaker, to be quite frank, it probably would help the HMO industry too, because all of these cartoons and jokes that we hear about are not a good thing for that industry. But if we had a fair process in place so that if one has a dispute with one's HMO, one would have a fair process to get that taken care of, and one would know that at the end of the day, if one did not agree with the company, we would have an independent panel to review it where the decision would be binding on the company.

I say to my colleagues, that would not increase lawsuits, that would decrease lawsuits. That would help prevent injuries or deaths from happening. I honestly think that that would be beneficial to the industry itself, because boy, they have got a real problem that in my opinion some of them really deserve.

So, Mr. Speaker, I am coming to an end here. I think that there are some ways where some common sense could help with the prescription drug problem, not just for senior citizens, but for everyone in terms of helping bring down the cost of prescription drugs. I think as we look at in the next week or so ways to help with some reimbursement issues for Medicare, we should be very careful about rewarding HMOs who, in many cases, are ripping off the system; and we should focus those dollars on the real areas that need to be fixed.

Finally, we have about 3 weeks, by my estimate, left here in Congress to get something done. The way it stands right now, if the Republican Senators who have voted for the Norwood-Dingell-Ganske bill, Senators MCCAIN, FITZGERALD, CHAFEE, and SPECTER, will stick to their past votes, they have already voted twice for real patient protection, if those Republican Senators will stick with their past votes, then if all of the Senators show up and we vote on that again, we have a 50–50 tie and Vice President GORE comes in and breaks the tie, and we will have signed into law a real Patients' Bill of Rights.

However, we have an alternative. The alternative is to look at this compromise language, to get some additional Republican support for this compromise language. We can add some important aspects of access to health care to that, some areas of real compromise with the Democrats, whether it is in the area of 100 percent deductibility for the self-employed or some additional tax credits for small businesses that offer health insurance, or even in the context of an overall agreement, maybe even an extension of medical savings accounts.

Mr. Speaker, there is a desire to get this done. That is why we have come up with this new compromise language. We do not want to put Republican Members of the Senate in a box and ask them to change their vote. That is why our compromise solution is there, so that they can come on board to a good piece of legislation, we can get this signed into law, and then we can go back to our voters in November and say, we have overcome a $100 million effort by a special interest group to keep the special protection that no other American business has. We are doing something in a truly bipartisan fashion so that our citizens back home in their time of need, when they really need to have their health insurance work for them, health insurance that they have spent a lot of money on, when they really need it, it will be there, and they can have confidence in being treated fairly.

That, Mr. Speaker, is what this is about. It is a big opportunity. I urge my colleagues on both sides of the aisle to take it.

REPORT ON RESOLUTION WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Mr. DREIER (during special order of Mr. GANSKE), from the Committee on Rules, submitted a privileged report (Rept. No. 106–882) on the resolution (H. Res. 586) waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules, which was referred to the House Calendar and ordered to be printed.

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HOUR OF MEETING ON FRIDAY, SEPTEMBER 22, 2000

Mr. GANSKE. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at noon tomorrow.

The SPEAKER pro tempore (Mr. BRADY of Texas). Is there objection to the request of the gentleman from Iowa?

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. GANSKE. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday next.

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

There was no objection.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. HASTINGS of Florida (at the request of Mr. GEPHARDT) for today and the balance of the week on account of personal business.

SPECIAL ORDERS GRANTED

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

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

Mr. BROWN of Ohio, for 5 minutes, today.

Mr. STRICKLAND, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. UNDERWOOD, for 5 minutes, today.

Mrs. MINK of Hawaii, for 5 minutes, today.

Ms. EDDIE BERNICE JOHNSON of Texas, for 5 minutes, today.

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

Mr. GOSS, for 5 minutes, today.

Mr. CANADY of Florida, for 5 minutes, today.

Mr. FOLEY, for 5 minutes, today.

Mr. SCARBOROUGH, for 5 minutes, today.

Mr. PICKERING, for 5 minutes, today.

ADJOURNMENT

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

The motion was agreed to; accordingly (at 5 o'clock and 16 minutes p.m.), under its previous order, the House adjourned until tomorrow, Friday, September 22, 2000, at noon.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

10188. A letter from the Associate Administrator, Department of Agriculture, Agricultral Marketing Service, Fruit and Vegetable Programs, transmitting the Department's final rule—Oranges, Grapefruit, Tangerines, and Tangelos Grown in Florida; Limiting the Volume of Small Red Seedless