

tests and treatment cost \$3,000. We can say that the cost ratio of the first doctor is 20-to-1, whereas the cost ratio of the second doctor is 30-to-1.

In certain managed care plans, such as health maintenance organizations, HMOs, with prepaid premiums, the doctor with the 20-to-1 cost ratio has preferable "economic credentials" in comparison with the doctor whose ratio is 30-to-1. If the managed care plan is going to make a profit, it will do better with the first doctor than with the second. So the plan gives the boot to the second doctor and welcomes the first one.

Essential to this program is knowing how much doctors actually cost the program in terms of expenses meted out for patients' medical care. These expenses used to be called medical care. Now they are characterized as losses, or expenses that rob corporate owners or shareholders of profit.

Keeping track of this data and using it to grant doctors membership in HMOs, independent practice associations, or hospitals is the backbone of economic credentialing. Unfortunately, this backbone is spineless and without soul. It doesn't care a whit about patients as people, but only about patients as progenitors of cost and expenses. Companies want to minimize these costs to enhance profits.

The danger is that physicians' "economic credentials" will become more vital to managed care companies than their medical credentials. Court decisions have not shot down economic credentialing.

In Florida, a doctor was denied membership on a hospital staff because he was already a heart surgery director at another hospital. In other words, his services were declined not because he could not measure up medically, but because he was viewed as an economic competitor.

In Los Angeles, a doctor was terminated from a health care plan based solely on a business and financial management analysis. The company told the doctor that, "This decision in no way is a reflection on your performance." An inquiry has been launched to discover if medical red-lining occurred.

In San Jose, a group of doctors in a managed care organization were issued an edict telling them that coronary stents, a type of heart surgery, no longer would be authorized. To ensure that the doctors took the edict to heart, so to speak, they were hammered with the following declaration, "If any charges are incurred for such (coronary stents), the cost resulting from such will be deducted from your income."

Patients need to know that before they join any managed care plan they must make sure the plan manages to take care of them before it takes care of its owners.

□ 1830

This advice will not be easy to follow. In some plans, doctors operate under "gag" or

"no-cause" clauses, legally imposed conditions, whereby participating doctors agree not to discuss with patients the plan's financial incentives for doctors.

Additionally, a doctor's criticism of a plan's refusal to provide diagnostic testing or recommended treatment may be treated as corporate disloyalty and grounds for dismissal.

In the meantime, it behooves patients and doctors alike to learn how the health insurance industry works. Otherwise, we risk being red-lined out of whatever health care coverage we believe we may still have.

This ends the editorial by Dr. Robert Weinmann in the San Francisco Examiner of Friday, January 12, 1996.

2000 CENSUS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mrs. MALONEY) is recognized for 5 minutes.

Mrs. MALONEY of New York. Mr. Speaker, I rise this evening to clarify the status of planning for the 2000 Census.

Some of my colleagues tried to give the impression that the Census Bureau is pursuing an illegal course of action by planning for a scientific census that will count all Americans. Nothing could be further from the truth.

There are three issues here: Number one, what have the courts said? Secondly, what were the terms of the agreement between the administration and Congress passed by the Commerce, Justice, State Appropriations bill last November? And thirdly, what is the appropriate course of action for the future?

Last month, the District Court for the District of Columbia issued a ruling in the case of the U.S. House of Representatives v. the Department of Commerce. That court ruled that the use of sampling in the census violates the provisions of Title 13 of the United States Code.

If this were the first ruling on this issue, this might be news, but it is not. The fact of the matter is, three district courts have ruled on this issue since 1980 and all three have come to the opposite conclusion.

Let me read to my colleagues a few of the other courts' decisions so that we can make up our own mind about the guidance from the courts.

In 1980, the United States District Court for the Eastern District of Michigan said, "The words 'actual enumeration' in Article 1, section 2, clause 3 do not prohibit an accurate statistical adjustment of the decennial census to obtain a more accurate count."

That court went on to address Title 13 and said, "There is nothing contained in Title 13, United States Code, section 195, as amended, which would suggest that the Congress was interested in terminating the Census Bureau's practice, manifested in the 1970 census, of adjusting the census returns to account for people who were not enumerated. All that section 195 does is prohibit the use of figures derived solely by statistical techniques."

In that same year, the United States District Court for the Eastern District of Pennsylvania said, "The court holds that the Census Act permits the Bureau to make statistical adjustments to the headcount in determining the population for apportionment."

In 1993, these concepts were restated by the District Court for the Eastern District of New York, which said, "It is no longer novel or in any sense new law to declare that statistical adjustment of the decennial census is both legal and constitutional."

Three separate district courts have ruled that the use of modern statistical methods to correct the census is both legal and constitutional. One district court has said that it is illegal and did not address the constitutional issue.

When agreement was reached last November to pursue the legality and constitutionality of the census plans in the courts, all agreed that the ultimate answer must come from the Supreme Court. This division among the district courts, even though it is 3 to 1, simply reinforces the wisdom of that decision.

If we were to draw a conclusion from the district courts, the smart money would be on the side of the Census Bureau. But that is not what we agreed to, and it is irresponsible to now chastise the Census Bureau for continuing down the path laid out last November.

Where do we go from here? The answer is obvious. We stay the course. That is not what the Republican majority is doing. Instead, they want to hold the funding for the second half of the 1999 census hostage because they fear that the Supreme Court will rule in favor of the Census Bureau.

The Republican majority's fight against the census has always been an issue of political survival, not one of getting the most accurate count. We need a scientific census, one that will count all Americans. We need to support the professional Census Bureau plan.

MANAGED CARE REFORM

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

Mr. PALLONE. Mr. Speaker, it is not my intention to use all the time this evening, but I did want to spend some time this evening to talk about managed care reform.

Today, after having spent the last month in their districts, Members of the House returned from Congress' annual August recess. And the month of August always provides Members with an extended opportunity to hear what is on their constituents' minds. And I just wanted to assure my colleagues that the number one issue on people's minds, at least in my district, continues to be managed care reform.

I think over the last 4 weeks I held about 20 town meetings or forums in

various municipalities in my district, and it was the issue people were most concerned about before we left in August and it continues to be the one that I hear most about at town hall meetings and the open houses that I have had in my district offices. And I think it will be the major issue that people worry about in terms of legislative action in this Congress and that we need to address the issue before this Congress adjourns sometime in October.

One of the things that a lot of people ask me is exactly what type of reform we have in mind. And I talk specifically about the Patients' Bill of Rights, which is the legislation that myself and other Democrats put forth before the House before the August break.

The Patients' Bill of Rights, the Democratic Patients' Bill of Rights, basically provides a number of patient protections, if you will, for Americans that are in a managed care organization, or HMO.

And just to give an example of some of the patient protections that we do provide in the Democratic bill, most important is the return of medical decision-making to patients and health care professionals, not insurance company bureaucrats.

Most of the people who have attended my town meetings or come to my district office complain to me about the fact that a decision about what kind of procedure or operation they might have or whether they are able to stay in the hospital after a particular operation or particular care that they need that that decision is increasingly made by the insurance company and not by the doctor.

The doctor may say to them, "Well, I really think you should be staying in the hospital a few more days," or the doctor may recommend a particular medical procedure or operation and the insurance company decides that they will not pay for it because they do not deem that operation medically necessary.

Well, it should not be the insurance company that makes that decision. It should be the physician in consultation with the patient. And that is what the Democrats are trying to do with our Patients' Bill of Rights, bring that decision about what is medically necessary back to the physician and the patient, to the health care professionals, not the insurance company bureaucrats.

The other major patient protection that we provide in our Democratic bill relates to access to specialists, including access to pediatric specialists for children. Many people have complained to me that if they need a specialist, sometimes a specialist is not available within the managed care network or that they do not feel that the person that they are referred to within the managed care HMO network really has the expertise that is necessary with regard to the care that they need.

And what we say in our Democratic bill is that they have to be guaranteed

access to a specialist. If in fact these specialists within the HMO network are not adequate, for example, if the HMO decides that they can see a pediatrician but not a pediatrician that has a specific type of expertise, then they have the right under the Democratic bill to go outside the network and the insurance company would have to pay for that specialist that is necessary even though it is not a doctor that operates within the HMO.

The other major issue that I hear constantly from constituents, probably even more so than any other, is coverage for emergency room care. Many insurance policies now that come under managed care, or HMOs, would say that in a given circumstance they might have to go to an emergency room, to a hospital, that is further away from where they are located, or if they do go to the emergency room, they may decide afterwards that it really was not an emergency, and therefore, they are not going to cover the care and they have to pay for it out of their own pocket.

Well, what the Democratic bill says is that if the average person, it is a standard we call a "prudent layperson" standard, if the average person, the average citizen, would feel that at a particular time they need to go to an emergency room because they have a particular type of pain or they have suffered a particular kind of injury, then they have the ability to go to the closest emergency room and the insurance company has to pay the bill.

It really is common sense. Most of these patient protections, Mr. Speaker, are nothing more than common-sense proposals that I think most Americans would feel that we already have. But we do not; we do not have these guarantees, and we need to make these patient protections, these guarantees, we need to make them the law of the land.

The other issue that comes up and another patient protection in the Democratic bill is the right to talk freely with doctors and nurses about every medical option. What we have found is that many of the HMOs now will simply tell the doctor that they cannot talk to the patient about a particular medical option, say, a particular procedure or operation, if they do not cover it. It is called a "gag rule." They basically implement a gag rule and limit what the doctor or the nurse can say.

That is not right. We live in a country where we value freedom of speech, and certainly we would expect that our physician would be able to tell us freely whether we need a particular procedure and what kinds of procedures or care are available.

The Democratic bill basically guarantees that there would be no gag rule and that the physician or the nurse would have the right to talk freely with the patient about medical options that might be necessary.

Also, in our Democratic bill we have an appeals process and real legal ac-

countability for insurance company decisions.

Now, let me talk a little bit about that. What I find is a lot of people will come to my office or they will testify at some of the hearings that we have had in Congress, and they will say that if the insurance company or the HMO denied them care and said that they could not have a particular procedure or said that they had to leave the hospital, and they tried to appeal it, they either filed a grievance or they called up the insurance company and said they did not agree with their decision and would like to have it reviewed, that right now, for most people, that is not really an option because the review, if there is one, is done internally by the HMO, by the insurance company, and they simply review their own decision and decide that they are wrong and that is the way that it is going to be.

Well, what we do in the Democratic bill is, we say that there will be an external review procedure, that it will not be the insurance company that they go to if they have a grievance or they want to appeal the denial of care. They get to go to an outside board that they do not appoint and they cannot influence that will decide whether or not that decision was accurate; and if it was not, they have the power to overturn the insurance company and guarantee that the care is provided or that the care is reimbursed for and paid for.

In addition to that, for many people now, if they are in what we call an ERISA plan, which is a plan where their company that is helping pay for the insurance is self-insured and, therefore, it comes under the Federal Government's review, that they may not have a right to sue the HMO or the managed care organization for damages that are inflicted because they denied them care. They cannot go to court and recover for the damages that occurred because they were denied a particular type of care.

Well, that is not right. People should be free, in my opinion, to be able to go to court and sue the HMO, sue the managed care organization, if they have been denied care and they suffered damages. And that is what we also say in the Democratic bill, that they will have that right.

Again, we are not talking about anything that anyone should be surprised about. It only makes sense that if someone injures them that they should be able to go to court and recover for their injuries.

And finally, there are a number of patient protections, but I wanted to talk about one more that I consider particularly important, and that is an end to financial incentives for doctors and nurses to limit the care that they can provide.

What we find now is that many insurance companies, many HMOs, many managed care organizations basically, give a financial incentive to the doctor

if they limit the care that is provided, so that, in a sense, they have an incentive because they are getting paid more, for example, if they do not do as much and if they can show over a period of time that they have not prescribed or recommended certain procedures that may be costly.

□ 1845

Well, again, that is just the opposite of the type of incentive that we should have. People should feel free, if their doctor thinks that they need care, that the doctor will recommend that the care be provided and not have a financial incentive not to provide it. Again, our Democratic bill makes it clear that that type of financial incentive to limit care is not allowed and is essentially made illegal.

Now, I wanted to talk about what happened here in the House before the break, before the August break. The House, of course, hastily considered a Republican managed care bill and the Democrat's Patients' Bill of Rights, which I have talked about this evening, was essentially defeated by about 5 votes, very narrowly, and I believe that the Republican leadership was anxious to get something passed so that the Republicans would have something to point to when voters raised the issue of managed care reform at town meetings and other opportunities back in our districts.

So what I want to stress tonight is that the Republican alternative to this Democratic Patients' Bill of Rights that I talked about this evening really is not going to do the trick. It is not going to be effective in providing patients with adequate protections.

I just wanted to spend a little time, if I could, talking about why this Republican plan that was passed in the House, and was basically passed and the Democratic plan was defeated, why this Republican plan will not work effectively to protect patients' rights and to reform HMOs and managed care. I do not do this in an effort to suggest that I am not open to alternatives that would come from the other side and come from the Republican leadership but I am concerned that if the Republican bill is the one that ultimately were to pass the Senate and go to the President's desk that it really would not do anything to improve the situation for health care for those in HMOs and, in fact, might make it a lot worse in terms of the kind of protections that people have.

I talked a little bit about access to specialists under the Democratic proposal. The Republican bill does not ensure access to specialty care. For example, if a child with cancer needed to see a pediatric oncologist, there is no requirement that he or she would have access to that specialist. If the HMO said, okay, we will provide a pediatrician for children but we are not going to provide any specialists for children beyond the basic pediatrician, then you would not have the ability under the

Republican plan to see a pediatric specialist or certainly to have the insurance company pay for it.

Protection of doctor/patient relationship, I talked about how one of the most important things that people bring up to me is the need to have the decision about what is medically necessary and what care is provided, that that decision be made by the doctor and the patient and not by the insurance company. Well, under the Republican bill, basically the insurance companies decide what is medically necessary. The health plan can define medical necessity any way it wants and if there is a review of a decision to deny care, then the review only goes back to what the plan originally provided in terms of what is medically necessary.

So, for example, if you want a particular type of operation and the HMO decides that they are not going to pay for it, well, they decide what is medically necessary, and if you go out and try to appeal that, the court or the appeal board would have to say, well, that decision about what is medically necessary is made by the insurance company. We cannot review it.

So, again, this is a major flaw. If the decision about what is medically necessary is decided by the insurance company essentially the patient has effectively no protection.

The other thing that I have not discussed tonight but I want to discuss, and I think is very important, is the whole idea of choice of doctors. Now, we know that the basic idea with an HMO or a managed care plan is that the plan is limited to a network of doctors that sign up and that you are allowed to choose from, but what we say in the Democratic plan is that we will do initially, when a patient decides what kind of health insurance to sign up for, that they must have the option of being able to sign up for an HMO that allows point of service; that allows them to go outside the plan and see another doctor even if it means they have to pay a little more. So that what we are saying is that you will have a choice in the beginning when you decide what kind of health insurance to buy, you will have a choice, other than a closed panel HMO.

Right now, many employers only provide what we call a closed panel HMO. In other words, you can take the HMO and they have their network of doctors and if you do not want to see one of those doctors, that is it. Those are the only choices you have. What we are saying in the Democratic bill is that initially you should be able to decide to have the point of service option so that you can go outside the network at your own option if you want to pay a little more for a physician that is not a part of the network.

Now, again, contrasting that Democratic proposal with the Republicans, what the Republicans put forward, they have a point of service option, if you will, but it is so full of loopholes as to make it essentially meaningless.

There are exemptions for Health-Marts. There are exemptions if the employer does not want to contract with the plan to do it; exemptions if premiums increase 1 percent. Basically, they are saying if the cost of premiums go up or if the employer doesn't want to have an option where you can go outside the network, then you do not get this point of service option where you can choose your doctor. So essentially they have not provided for a point of service where you can choose your doctor.

Again, talking to many of my constituents during the August break, this was a very important point, that they wanted to have that option if they wanted to go outside of the network and choose a doctor, even if it meant that they had to pay a little more.

The other thing that I wanted to mention is, again, with regard to specialists, there are a few things that the Democratic bill does that the Republican bill does not do. First of all, we allow women to choose their obstetrician or the gynecologist as a primary care doctor. That is not allowed under the Republican plan. Again, this is important, because if your OBGYN is your primary care doctor then that person can make referrals to other specialists. If they are not, then you are dependent upon the general practitioner essentially to make those kinds of referrals.

Let me also talk about emergency care again and how the bills differ, how the Republican and the Democratic plan differ. In the Democratic plan, we specifically say that severe pain is a basis for going to the emergency room. Like, for example, if you have severe chest pains and the average person would think well, that is a good enough reason to be able to go to the emergency room that is closest to me, well, the Republican bill does not include that so that essentially, again, it is up to the insurance company to decide whether or not there was justification for you to go to the emergency room. To me, that is very important.

I do not want to have to second-guess, when I have severe chest pains, whether or not it is strong enough for me to have to go to the emergency room. I would think that the average person would think if they have severe chest pains that they go to the emergency room and they get care and it is going to be covered. That is the way it should be. Unfortunately, that is not the way it is under the plan that the Republican leadership brought forward here a few weeks ago before we had the August break.

Now, I just wanted to talk about a few other things that the Republican bill does that I think ultimately cause the situation even to be worse in terms of patient protections and health care. The Democratic bill is pure in the sense that it seeks to address the issue of managed care reform and HMO reform directly without adding a lot of other things. When we talk about

health care in the House of Representatives amongst our colleagues, Democratic and Republican, we know that there are a lot of issues that need to be addressed. For example, one of the biggest concerns I have is the fact that so many people are uninsured and have no insurance. The number keeps growing.

Others want to address the issue of malpractice reform, because they think that physicians in many cases are too liable for malpractice and that we need to address that issue. Others feel that there needs to be ways to expand and experiment with other kinds of health insurance that many people do not have right now. Well, all that makes sense and certainly are things that we should look into, but what the Republican bill has done, and I think it is purposeful, is to throw a lot of these things that are unrelated to managed care reform into their legislation, which will make it very difficult for the legislation to move forward.

Now, again, we only have about a month here from today until we are scheduled to adjourn. It is going to be very difficult in that month to get anything passed. So if you overlay legislation dealing with managed care reform with all these other concerns, you are pretty much guaranteeing that we are not going to address the issue.

Well, what the Republican leadership has done is they put in their legislation medical malpractice reform. They have also said that if companies right now that are self-insured and come under the Federal law, under the ERISA, if a group of companies want to get together and start their own self-insurance pool, that they also will be exempt from State laws and come under Federal law and be under ERISA and also, therefore, there would not be the ability to sue.

Well, throwing that in, throwing in, again, an expansion of self-insurance and bringing it under ERISA is another sort of poison pill that takes away from the real issue at hand, which is managed care reform.

So we have the medical malpractice reform, we have the expansion of ERISA, and a third thing that we also have is expansion of medical savings accounts. Medical savings accounts were started on an experimental basis last year when we passed the Balanced Budget Act and it is a very controversial way of basically allowing people to take money, for example, in the case of Medicare, if you had a medical savings account under Medicare, if you decide to have a very high deductible and pay out-of-pocket for most of your every day health care expenses, then the Federal Government would give you money in a savings account from Medicare, from Medicare funds, rather than pay for your health insurance for most of the normal daily occurrences that might result in your need to have health care. So you basically get an account coming from the Federal Treasury for you to save money as opposed to getting your health insurance paid

for. You have to pay out-of-pocket from that account.

Well, it is an idea that some people think needs to be looked into and we do have it on an experimental basis, but what the Republicans have done in their bill is to allow this to be expanded to cover a lot more people in the context of the managed care reform that I have been talking about this evening.

Well, once again, that is a poison pill. That is a controversial issue, along with the medical malpractice reform and the expansion of ERISA, that needs to be debated, needs to be discussed a lot more by the House of Representatives and by the Senate. If we throw that into managed care reform, we are basically going to kill managed care reform and not allow it to come to the floor and really be passed and considered in the month or so that we have left here before we adjourn.

So what I am asking tonight, and I will be saying it many more times over the next month while we are in session, is that we put partisanship aside, we put all of these other issues aside that really do not relate to managed care reform, and we try to get to the heart of the matter. Americans from all walks of life, no matter how poor, no matter how rich, no matter how young, no matter how old, that I have talked to in my district and even from other parts of the country feel that this issue of HMO reform needs to be addressed and needs to be addressed now. We need to address it before we adjourn. We should get together and pass something, pass the Patients' Bill of Rights with the patient protections that I outlined or at least something very similar to it.

□ 1900

I am just hopeful that on this first day when we are back, and, of course, there are a lot of other things on our mind here in Congress, that we pay attention to this and try to get HMO reform approved before we adjourn sometime in October.

IMPORTANCE OF PERSONAL HEALTH CARE

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

Mr. CUNNINGHAM. Mr. Speaker, in a way, I am going to talk about health care, but I am going to talk about personal health care. The reason is that I am a prostate cancer survivor. Three weeks ago I had prostate cancer and it was removed out of my body. I would like to go through the process and describe how many men and women, both with breast cancer and prostate cancer, can have a good diagnosis.

That diagnosis is based on early detection. Many HMOs do not offer a PSA, which is an indicator for an anti-

gen produced by prostate cancer. TRICARE for veterans does not necessarily offer a PSA.

Let me tell you why that is important. First of all, about a month ago Dr. Eisold here in the Capitol, who is the attending physician, gave me my annual physical. I have had an annual physical for the last 30 years. Every year for 20 years in the military they demanded it as a pilot, and then, after that, I know the importance of an annual physical.

This time they wanted to do a prostate check. I am over 50 years of age, and it should be checked every year. Well, they did the regular prostate check, and they found nothing. There was no cancer, there were no lumps, there were no lesions, and there was no metastasized area.

Then the doctor looked at a blood test, which was painless, and in that blood test, a PSA, which, again, is a check for an antibody that prostate cancer produces, and I had a slight elevation in the level; not real high, but just a slight elevation.

Now, normally you would do the physical check and that would be it. You would think you were cancer-free. So the doctor ordered a sonogram, which takes a look at the internal aspects of the prostate itself, and in that they found no tumors as well, no cancer. So then they did an MRI through the whole pelvic region and found no tumors, no cancer.

Another reason I am alive today is that the doctor, besides having a good health care system, besides having a doctor that was thorough, that not only just gave you a blood test, but he read the results and was insistent upon going through and analyzing all the different aspects of the diagnosis, said "Duke, we want to perform a prostate biopsy."

Now, I would rather fly over Hanoi again than get a shot, so you can imagine, Mr. Speaker, the dismay the night before. I imagined a needle this long that they were going to take and stick in my prostate and take out these core cells.

When I got out to Bethesda, the doctor and the clinician prepared me, and they said, "Duke, this is not going to be real painful." And I said, "Yeah, right." It is like sitting in a dentist's office, and you are just waiting for that drill to hit a nerve. What it is is they take six core cells each time out of your prostate, and there is a little needle with a mechanism that fires and takes out a core cell.

The first one he said it is going to sound like a cap gun goes off. So you are sitting there waiting for this immense pain to happen, and you hear the snap and you flinch, but there was no pain, not even a prick. At that point you are sitting there waiting; okay, I have got 5 to go, I know the next one is going to hurt. Well, they did each and every one of those core samples, and there was no pain.

The point I want to make is that for the men, Mr. Speaker, if you are asked