Souder
Spence
Stearns
Stump
Sununu
Sweeney
Talent
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson
Wolf
Young (AK)
Young (FL)

NAYS—205

Abercrombie
Ackerman
Allen
Andrews
Baird
Baldacci
Baldwin
Barcia
Barrett (WI)
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Campbell
Capps
Capuano
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Crowley
Cummings
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Ganske
Gejdenson
Gephardt
Gilman
Gonzalez
Green (TX)
Gutierrez
Hall (OH)
Hall (TX)
Hastings (FL)
Hill (IN)
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Hooley
Hoyer
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Larson
Lee
Levin
Lewis (GA)
Lofgren
Lowey
Luther
Maloney (NY)
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Minge
Mink
Moakley
Mollohan
Moore
Morella
Murtha
Nadler
Napolitano
Neal
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pickett
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Scott
Serrano
Sherman
Shows
Sisisky
Skelton
Slaughter
Snyder
Spratt
Stabenow
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Traficant
Turner
Udall (CO)
Udall (NM)
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Weiner
Wexler
Weygand
Wise
Woolsey
Wu
Wynn

NOT VOTING—2

McKinney
Scarborough

□ 1724

Mrs. ROUKEMA changed her vote from ''nay'' to ''yea.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate agrees to the report of the Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2606) ''An Act making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes.''

The message also announced that pursuant to Public Law 104–1, the Chair, on behalf of the Majority and Minority Leaders of the Senate and the Speaker and Minority Leader of the House of Representatives, announces the joint appointment of the following individuals as members of the Board of Directors of the Office of Compliance—

Alan V. Friedman, of California;

Susan B. Robfogel, of New York; and

Barbara Childs Wallace, of Mississippi.

PERSONAL EXPLANATION

Mr. WATTS of Oklahoma. Mr. Speaker, this afternoon I recorded my vote by electronic device in favor of the rule to consider the Quality Care for the Uninsured Act, H.R. 2990. Subsequently and unexpectedly, that vote was reordered due to a failure with the electronic eqipment, and I was not advised of this in time to return to the Capitol to recast my vote.

BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999

The SPEAKER pro tempore (Mr. SHIMKUS). Pursuant to House Resolution 323 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2723.

□ 1725

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, with Mr. HASTINGS of Washington in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Virginia (Mr. BLILEY), the gentleman from Michigan (Mr. DINGELL), the gentleman from Pennsylvania (Mr. GOODLING), the gentleman from Missouri (Mr. CLAY), the gentleman from Texas (Mr. ARCHER), and the gentleman from New York (Mr. RANGEL) will each control 30 minutes.

The Chair recognizes the gentleman from Virginia (Mr. BLILEY).

Mr. BLILEY. Mr. Chairman, I yield myself 6 minutes.

Mr. Chairman, over 5 years ago, Republicans in Congress stood efficient against a very bad idea, an attempted Government takeover of our Nation's health care system. Back then, we opposed President Clinton's vision of health care reform primarily because of the negative effects his proposal would have on employers and the negative effects it would have on consumers' ability to choose their own physicians.

Mr. Chairman, we won that debate over how to best reform our health care system. We won that debate because the public agreed that Government micromanagement of our health care system was wrong. The public agreed that imposing expensive new burdens on employers would result in an increase in premiums and would cause businesses to drop their health care coverage.

Now today we are faced with another debate about the direction of our Nation's health care system. Mr. Chairman, once again, we must decide whether we want to move toward a Government-controlled health care system or instead enact reasonable protections for patients that maintain quality without driving up costs. I stand here today with a firm hope that we will prevail in this fight similar to the way we did 5 years ago.

Mr. Chairman, I do not think that anyone would question my long-standing commitment to ensuring that the United States maintains its high quality health care system and that Americans of all walks of life have access to that system.

□ 1730

Unfortunately, I believe that H.R. 2723, the Norwood-Dingell bill, is misdirected in several fundamental ways and ultimately will harm the very people it intends to help.

My views on health care reform are fairly straightforward. First, we should do no harm. Doctors take the Hippocratic oath; we legislators should follow a similar injunction. We should vote down health reform legislation that harms patients. We should avoid legislation that increases the number of uninsured in this country. For all the attention that has been given in this debate to denied care, I think we should focus on the worst kind of denial, and that is denial to any form of health insurance at all.

Forty-four point three million persons are uninsured today, and we ought not be adding to that number; we should be subtracting from it.

Second, when we do enact patient protections, they should be just that, patient protections; not provider protections, not insurer protections but patient protections. That is why I have been an ardent supporter of a fair and just external review process.

My colleagues have heard me say ''care, not court.'' A patient in need of care needs medical treatment not legal treatment. In my opinion, H.R. 2723 goes way too far on liability and will simply be a treasure trove for trial lawyers.

By overreaching on the constraints it imposes on valid cost containment techniques, this bill poses a real threat to the voluntary, employer-sponsored health insurance system prevalent today.

I know how price-sensitive employers are. I was a small business owner myself some time ago. The Norwood-Dingell bill takes a reasonable idea, and then it takes it way too far. As a result, costs will needlessly go up and not always for the betterment of health care quality. For example, the bill does not have a point-of-service exemption for small employers. Due to this omission, many small business owners, who can least afford to contribute to health care coverage for their employees, will be left with the choice between providing Cadillac care or no care at all. Many of their employees will lose their employer-sponsored insurance because the point-of-service mandate will drive health care costs up.

The bill's whistleblower provision is another example of a reasonable idea gone bad, and the list goes on.

This bill micromanages a plan's utilization review requirement.

It gives too much secretarial authority in the selection of external review entities and in specifying the standards of review.

Even the bill's definition of medical necessity extends beyond what is needed to ensure that patients receive the most appropriate care.

Mr. Chairman, I could go on and on and discuss other concerns I have and point out the breadth of the bill's onerous ''any willing provider'' provisions and the lack of a conscience clause, but there are other Members here who wish to have their say.

Let me simply conclude as follows: As the chairman of the Committee on Commerce, I have reached across the aisle to draft reasonable patient protection legislation with my colleagues. While some amount of this bill reflects that effort, in the end the authors went too far, as I have said. This is unfortunate, and this is why I have cosponsored H.R. 2926 instead.

As I have said, my goals throughout have been to provide better, not worse, care to the American people; to provide access to needed medical care, not to courts of law; and to provide patient protections, not protections for the interests of providers or insurers.

Mr. DINGELL. Mr. Chairman, I ask unanimous consent that I may yield 15 minutes of the time available to me to the gentleman from Georgia (Mr. NORWOOD), to be controlled by him.

The CHAIRMAN. Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. NORWOOD. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I appreciate the opportunity finally, after 5 years, for us to come together and decide an issue that has really confronted this body for 5 years, but the truth is it has confronted the American patient for 25 years.

The issue is whether managed care insurance companies can be held truly accountable in court when they breach their contract and someone is injured or dies.

Since 1974, this Congress has given HMOs a free pass to deny promised benefits without any legal responsibility for the damages that they do and have caused.

Are we willing to correct this injustice, finally, after 25 years? If so, we simply must pass a bill that can become a law which reverses that 1974 mistake, and a bill that we are certain will be signed by the President. We must also be able to answer in the affirmative the following question: If someone makes a wrongful medical decision or breaches their contract and a member of someone's family dies, will that family have an absolute, unconditional right to seek redress in court? Yes or no, no strings attached?

There is only one bill that we will consider that can pass this test, and that is a bipartisan bill supported by both Republicans and Democrats. I believe that everyone in this body knows that to be a fact. To cast a vote really for any other bill is to cast a vote to block managed care reform.

Not one Member of this body will be able to hide behind a vote for a watered-down bill that cannot become a law and claim to be on the side of patients. We know better. The American people know better. Vote no, Mr. Chairman, on every substitute. Vote yes on the only legislation that has really a chance of becoming law and changing the disaster that this Congress visited on the American people with the 1973 HMO Act and the 1974 ERISA Act.

Mr. Chairman, I reserve the balance of my time.

Mr. DINGELL. Mr. Chairman, I yield myself 3 minutes.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Chairman, this is an old story. Last year, the industry spent $75 million to defeat legislation similar to that which we are considering today. Reports today indicate they will be spending in excess of $100 million for that purpose. Tonight they will be launching another new ad campaign with pictures of sharks and music from Jaws.

What scared them so much? Could it be they are afraid of paying for someone's cancer screening? Are they terrified of paying for surgery to some person who needs it? Is it the threat of paying for prescription drugs that has them petrified? Or maybe they are afraid of letting ordinary people make the decisions that affect their own lives.

Maybe they are afraid of the mother whose child has leukemia and wants the pediatrician to decide what care her child needs or perhaps a terminally ill cancer patient who has no other treatment available to save his life, other than a clinical trial.

Perhaps that patient needs to have an oncologist as his principal medical advisor. Maybe it is a woman in her second trimester of pregnancy whose doctor is dropped from the health care plan, or maybe it is a woman with breast cancer who has a mastectomy and is sent home that same day, or the man with a stroke who needs follow-up visits to a physical and speech therapist to regain full function.

The Norwood-Dingell bill would help each of these people get and continue the health care they need. None of the other substitutes can truthfully make that claim. The gentleman from Georgia (Mr. NORWOOD) and the gentleman from Iowa (Mr. GANSKE) and I have been working on these issues for years. Our bill has been totally vetted. We have even incorporated suggestions from other Members, including the gentleman from Oklahoma (Mr. COBURN) and the gentleman from New York (Mr. HOUGHTON).

We are going to hear a lot of rhetoric about lawsuits, and it is one thing which is perhaps one of the significant differences between these bills. Yes, we allow patients to hold their health care plans accountable if they cause harm or death when they make a medical decision. That should be. A right without a remedy is of no value.

All we have done is the same thing they did in Texas, where a law enacted during the tenure of Governor George Bush does these things. In 2 years since that law has been in effect, Texas has had exactly 5 lawsuits. The cost of such a situation, according to Coopers & Lybrand, a major accounting firm, amounts to 13 cents a month.

Let me remind all here, only one of these bills that is considered today was written before yesterday. They are all brand new, except the one which is offered by the gentleman from Oklahoma (Mr. COBURN), the gentleman from Iowa (Mr. GANSKE) and I.

All of our bills have been examined in broad daylight. The others have not. There is only one bipartisan bill. There is only one that has a chance of being signed into law. Only one has been endorsed by more than 300 organizations, including doctors, teachers, consumers, union members, specialists, women and others, including the league of voters, and all of the consumer organizations.

Only one has a chance of really making life better for people who buy health insurance and only one gives the people a clear right to the care which they need and which they deserve. Only one will be signed by the

President. Vote for Norwood-Dingell and support a bill that is going to benefit the people.

Mr. Chairman, I reserve the balance of my time.

Mr. BLILEY. Mr. Chairman, I yield 5 minutes to the gentleman from Tennessee (Mr. BRYANT).

Mr. BRYANT. Mr. Chairman, I thank the gentleman from Virginia (Mr. BLILEY) for yielding time to me.

Mr. Chairman, as a former attorney who practiced malpractice law and defending health care providers, I can say part of the problem with our health care system is the cost of that. It is simply too expensive. A lot of that cost is driven up by lawsuits where doctors have to practice defensive medicine in the event they might be sued later on. Common sense would tell us that if we are going to try and work in this situation and make health care more affordable and more accessible, then common sense would tell us that we ought to be able to try and reduce the cost here so that we can make health care more affordable and keep more people in the health care market. That would be the commonsense approach.

Now, the other approach, which is supported by the President and some here in Congress, would seem to allow the public to sue their way to more affordable health care; but according to the Congressional Research Service, expanding liability in an unrestricted fashion could result in private employer-sponsored plans, and these are the people who provide insurance to their employees, it could cause these plans to increase by 70 to 90 percent in premiums.

Just as medical malpractice liability induces health care providers to practice defensive medicine, again do this so I will not be sued or in case I am sued I have myself covered here, so would expanding liability to managed care in an unrestricted fashion. It would result in those employers and insurers and HMOs and third party health plan administrators beginning to approve unnecessary or inappropriate tests and procedures that are expensive, that will drive up the cost, all out of a fear of being sued. These added costs would then have to be passed on to employers who would then have to pass them on to their employees in the form of increased premiums and planned administration fees or simply do the easy thing and that is just quit providing health insurance to their employees.

Why fight that? If someone thinks suing a company for $4 million for a spilled cup of coffee was excessive, wait until they see some of the lawsuits and some of the awards which could result from the passage of this plan.

With health care representing over one-seventh of our economy, the odds of hitting the lawsuit lottery will expand exponentially. If the cost of providing health insurance actually goes up under this plan, which is supported by the President, who actually benefits? The discussion from the other side would have people believe it is the public; but if the costs go up, I fail to see how it is going to help those 44 million Americans that we have talked about heretofore afford health care coverage.

So who, in reality, does benefit from more lawsuits? Well, who gets over one-third in fees of the millions of dollars which have been awarded in our lottery-style court system? I think if we answer that question, we will find out who actually is being protected here; and those are some of those trial lawyers.

□ 1745

Mr. Chairman, this is not hard. Let us not turn this patient protection effort into a lottery. Let us instead try to find a way to find a balance here that would hold managed care people accountable, they ought to be held accountable, but yet do so in a fashion which does not drive up the cost of this health care; does not cause them to practice defensive medicine for fear of being sued or for these lottery-style judgments, but yet do the right thing and also keep these employers in the business of providing insurance for their employees.

What we do not want to do by this plan is to put more people into that 44 million uninsured classification simply by virtue of the fact that it is just easier, less expensive, less risk involved if they do not provide health care insurance for their employees, and I think we can do that.

Mr. Chairman, I trust this Congress has that ability to pass such a law that would provide that proper balance of accountability weighed against the cost and exposure and the risk and people dropping out of the market. I hope we can.

Mr. NORWOOD. Mr. Chairman, I yield myself 1 minute which I need to respond to my friend from Tennessee.

I am delighted that our lawyer friends would like to see some type of legal reform.

Would I agree that we need to stop the extortion, and frivolous lawsuits and all those things that cause defensive medicine prices to go up that I have lived with all of my life? Absolutely right. But legal reform can never mean that we take the civil rights or the due process away from 160 million Americans across this country and simply say, In your case with health care insurance you're on your own, baby.

Now we have got external review that is going to stop most of that anyway; it is going to be very hard to be negligent. And I think we are not going to find this big rash of lawsuits. But to say, Americans, the justice system is not there for you when somebody denies you a benefit that damages you and kills your child, what kind of justice system is that? Are we going back to six guns and the OK Corral when one is wronged? No, I do not think so.

The good news is that ours is very modest. We go back to the States where we took this away from them in 1974.

Mr. Chairman, I yield 2 minutes to the gentleman from California (Mr. HORN).

(Mr. HORN asked and was given permission to revise and extend his remarks.)

Mr. HORN. Mr. Chairman, for all the controversy surrounding this debate the issue is very simple: responsibility. Just as doctors are held accountable for the care they provide, just as manufacturers are held accountable for the safety of their products, so too should HMOs be held accountable for the consequences of their decisions.

Mr. Chairman, the Norwood-Dingell-Ganske bill simply sets up mechanisms to enforce the existing contractual agreements between patients and their health insurance providers. No health insurance plan should be allowed to avoid paying for necessary medical treatment for those who have faithfully paid their premiums each month by inventing its own definition of medical necessity. When health plans tell consumers that a requested treatment is not medically necessary, they are practicing medicine as much as a doctor who reaches the same conclusion. This shield of ERISA allows HMOs to escape the consequences of their decisions.

I know of no other business in America which has such immunity. With this bill we want to drive the quality of health care in this country not by encouraging lawsuits, but by encouraging HMOs to use the best medical science when providing care instead of using the bottom line. Medical necessity must be determined by physicians and their patients, not by MBAs and people that have not had a medical experience and not by profit margins and HMO bureaucrats. Norwood-Dingell-Ganske is the only bill that does just that. Support it.

Mr. Chairman, for all the controversy surrounding this debate, the issue is very simple. Responsibility. Just as doctors are held accountable for the care they provide, just as manufacturers are held accountable for the safety of their products—so too should HMOs be held accountable for the consequences of their decisions.

The Norwood-Dingell bill simply sets up mechanisms to enforce the existing contractual agreements between patients and their health insurance providers. No health insurance plan should be allowed to avoid paying for necessary medical treatment for those who have faithfully paid their premiums each month by inventing its own definition of ''medically necessity.'' When health plans tell consumers that a requested treatment is not ''medically necessary,'' they are practicing medicine as much as a doctor who reaches the same conclusion. This shield of ERISA allows HMOs to escape the consequence of their decisions. I know of no other business in America which has such immunity.

With this bill, we want to drive the quality of health care in this country—not by encouraging lawsuits, but by encouraging HMOs to use the best medical science when providing

care, instead of using the bottom line. Medical necessity must be determined by physicians and their patients, not by profit margins and HMO bureaucrats. Norwood-Dingell is the only bill that does just that.

Mr. BURR of North Carolina. Mr. Chairman, I ask unanimous consent that I be permitted to control the time of the gentleman from Virginia (Mr. BLILEY).

The CHAIRMAN. Is there objection to the request of the gentleman from North Carolina?

There was no objection.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Chairman, I rise in very strong support of the Bipartisan Consensus Managed Care Improvement Act of 1999. I commend the gentleman from Georgia (Mr. NORWOOD) for his heroic leadership in this issue.

The passion of the gentleman from Michigan (Mr. DINGELL) for health care was inherited from his father, John Dingell, Sr., who introduced the first bill in Congress to make health care available to all Americans, and I am sure that he would be very proud of his son today. At last we can enact real managed care reform and improve patient care across this country. The Norwood-Dingell bill was not written by special interest groups. It is the result of listening to what I call the other voices, those of patients and providers who have been left out of this dialogue.

As a nurse, I am also speaking on behalf of over 2 million nurses who have known for a long time that HMO reform is necessary, and I am proud that the American Nurses Association has offered a strong endorsement of this legislation, and I enter their letter as part of the RECORD:

AMERICAN NURSES ASSOCIATION,
Washington, DC, September 29, 1999.

Hon. LOIS CAPPS,
House of Representatives, Washington, DC.

DEAR REPRESENTATIVE CAPPS: As the House prepares for floor consideration of patient protection legislation, I am writing to express the American Nurses Association's strong support for the Bipartisan Consensus Managed Care Improvement Act of 1999, HR 2723.

The American Nurses Association is pleased to endorse this bill and is encouraged by the cooperation and compromises made to achieve real progress on managed care reform. This legislation constitutes an important step in assuring that strong, comprehensive, and enforceable protections will be in place for all insured Americans.

ANA believes that every individual should have access to health care services along the full continuum of care and be an empowered partner in making health care decisions. Given the nursing profession's preeminent role in patient advocacy, ANA is particularly heartened by the steps proposed to protect registered nurses and other health care professionals from retaliation when they advocate for their patients' health and safety. As the nation's foremost patient advocates, registered nurses need to be able to speak up about inappropriate or inadequate care that would harm their patients. Nurses at the bedside know exactly what happens when care is denied, comes too late or is so inadequate that it leads to inexcusable suffering, which is why the strong whistleblower protection language in this bill is critical to patient protection legislation.

ANA also believes that accountability for quality, cost-effective health care must be shared among health plans, health systems, providers, and consumers. The provisions of HR 2723 that assure a truly independent appeals system and legal accountability for health plans are reasonable and necessary if we are to have reform that is comprehensive and enforceable for all participants in the health care system.

This important bipartisan compromise also includes an important requirement that health plans allow patients to have access to a full range of health care providers, with no discrimination against some providers solely on the basis of type of licensure. ANA also strongly supports the provision assuring that women have direct access to providers of obstetric and gynecological services.

The American Nurses Association, which represents registered nurses throughout the nation who practice in every health care setting, urges support for HR 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999, the only patient protection bill to be considered by the House that will bring about genuine reform in our health care system.

Sincerely,

BEVERLY L. MALONE,
President.

This bill contains common sense provisions so important in the lives of ordinary Americans. It allows patients to choose their doctor and hospital and to see needed specialists. It leaves the determination of medical necessity with doctors, not insurance clerks. It guarantees emergency room care and ensures access to clinical trials. It allows patients recourse when they have not received proper care. This bill also includes whistle-blower protections which prevent nurses and other health care professionals from being fired if they report dangerous abuses.

Mr. Chairman, in my travels around the central coast of California it is heartbreaking to listen to so many families whose HMO horror stories have ruined their lives. In this, the greatest Nation of the earth, the time has come to put patients before profits. Let us pass this bipartisan bill. Stop the abuses of managed care.

Mr. BURR of North Carolina. Mr. Chairman, I yield 3 minutes to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. I thank the gentleman from North Carolina for yielding this time to me.

As my colleagues know, several times today we have asked ourselves why we are here, and what we have already heard in the first part of the debate is some of us are here to take a cheap partisan shot, some of us are here to build a career in Congress, some are here to get an electoral advantage. I am here to help patients, and I have already heard that the only bill that can do that is the bipartisan bill, and I adamantly and flatly disagree with that.

The American public needs to ask themselves why the persecution complex of the American Medical Association would say because we get sued so much we want everybody else sued.

There is a 1990 study out of the University of Indiana that says American doctors at that time ordered $33 billion worth of tests that were unneeded because of the fear of being sued. It is a legitimate concern to consider what the unintended consequences of uncontrolled lawsuits are going to be. Some will say we are going too far. That is what people say about the bipartisan bill. Some would say we are not going far enough. That is what they say about the Boehner bill. What we have to do is find a balance between both extremes, one that holds plans accountable, that does not raise costs and in fact can be enacted.

There is some perverse incentives out there that my friend, the gentleman from Georgia (Mr. NORWOOD), and the gentleman from Iowa (Mr. GANSKE) have worked hard to try to change with their bills, and I applaud them in their efforts to doing that. But to get a bipartisan bill, what happened is the group of people that they listed in support of their bill, they just happened to fail to mention that the trial lawyers are in strong support of their bill. Why would they be? Because one out of every $3 that is ever going to come out of this system to, quote, ''protect patients'' is going right into their pockets.

So there needs to be a balance; there needs to be accountability. We can do that.

And some have talked today about poison pills. We need to be real careful with that because, if in fact we care about patients, there is no such thing as a poison pill, there is no such thing as a poison pill. If my colleagues care about fixing the great inequality in our laws for patients, if my colleagues care about the future of voluntarily giving workers benefits, if my colleagues care about restoring the responsibilities on both sides of the doctor and patient relationship, then we cannot have too far reaching either way. We have got to have a balanced approach.

There is going to be several votes that we are going to take. If my colleagues care about fairness and finally again if my colleagues care about patients, they are going to consider the one that is just right, the one in between, the one that holds plans accountable, that does not raise the costs.

And, Mr. President, I would say to him, When you talk about vetoeing a bill that has access, that has limited liability, what you are saying is you really don't care about patients either. What you care about is a partisan political advantage and the fact that we will not enact a law that will save our patients and give them the freedom that all the rest of us have.

Mr. BROWN of Ohio. Mr. Chairman, I yield myself 2 minutes.

I am going to vote for the Norwood-Dingell-Ganske bill and against all the substitutes, and here is why:

The Norwood-Dingell-Ganske bill is the product of negotiations among

three Members of Congress who believe in patient protections so strongly that they have devoted more than 3 years to the passage of comprehensive reform. They know what they are doing, and the Norwood-Dingell-Ganske bill gets it. To protect patients we just cannot fix discrete problems as they pop up. We would be at that task forever. We need to make it in HMO's best interest to do the right thing without hand holding or without prompting. That is what accountability is all about; that is what the Norwood-Dingell-Ganske bill does.

As most of my colleagues know, Texas allows its citizens to sue managed care plans in State court. This bill says that all Americans should have that same right as people in Texas do. Most of my colleagues probably also know that there have been only five cases in the 2 years since the Texas law went into effect.

One of those cases should silence every single opponent of the Norwood-Dingell-Ganske bill. It involves a doctor who refused to refer his patient to a specialist. Why? It turns out that the patient's HMO told this doctor that if he referred even one more patient to a specialist, he would be kicked out of the provider network permanently and financially penalized. Apparently, Mr. Chairman, he had passed his quota.

Managed care organizations take huge gambles that they perceive as benign business decisions at our expense. We need to raise the stakes. That is what the Norwood-Dingell-Ganske bill does. If we want to protect patients now and in the future, it is the bill we should all vote for.

Mr. Chairman, I reserve the balance of my time.

Mr. BURR of North Carolina. Mr. Chairman, I yield 30 seconds to the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Chairman, I think we just need to address what was just said because what was just said was misspoken.

The State of Texas allows a suit on quality of care only, not on benefits. The Norwood-Ganske-Dingell bill covers both of those. The coalition bill allows any State to set up the same law that Texas has, but it reserves the right for benefits to the ERISA plans where they should be reserved.

So any State can do what Texas can do under either of the two options.

□ 1800

Mr. NORWOOD. Mr. Chairman, it is my great privilege, pleasure, and honor to yield 3 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I thank the gentleman from the great State of Georgia, who has led the fight on patient protection, for yielding me this time, and my colleagues on the other side of the aisle, the gentleman from Michigan (Mr. DINGELL), and so many others that I recognize from the many nights we have had here on the floor.

Mr. Chairman, why are we here? We are here because patients have been harmed by HMOs because they have made medical decisions. It started out a couple years ago. Remember, we had 285 cosponsors to ban gag clauses.

Here we have a cartoon, a doctor is talking to his patient, he says, ''Your best option is cremation. $359, fully covered.'' The patient is saying, ''This is one of those HMO gag rules, isn't it doctor?''

There were problems with all sorts of denials of care; right? Here is the HMO claims department. ''No, we don't authorize that specialist. No, we don't cover that operation. No, we don't pay for that medication.'' And the lady at the desk at the HMO suddenly hears something and she says, ''No, we don't consider this assisted suicide.''

Or how about the HMOs that decided they were going to do drive-through deliveries. Here we have the counter at the hospital drive-through window. ''Now only 6 minute stays for new moms.'' And we have the mother there, her hair like this, getting her baby.

And, do you know what? This affects real people. This lady here with her family is no longer alive because an HMO made a medical decision where she lost her life.

This lady who fell off a 40-foot cliff found that her HMO would not pay her bill because she did not phone ahead for prior authorization.

This is a patient of mine, a child born with a birth defect. Guess what? Fifty percent of the surgeons who correct this have found that HMOs deny coverage for this birth defect because it is ''cosmetic.''

And this little boy, this beautiful little boy, clutching his sister's shirt sleeve. Guess what? After his HMO care, he no longer has any hands and feet, and the judge that looked at that case said that HMO's margin of safety was ''razor thin.''

Look, I call upon my colleagues on both sides of the aisle: Vote for the bill that will correct these HMO abuses. Vote for a bill that will make sure that patients do not lose their hands and their feet before it happens. That is the Norwood-Dingell bill. It is the only bill that has been endorsed by over 300 organizations. It is the only bill that has been endorsed by nearly every consumer group, by nearly every patient advocacy group, by the provider groups, by the AMA. It is the only bill that the AMA has endorsed. The AMA is recommending a ''no'' vote on all substitutes. Look, why is that? It is because we need to fix this Federal law.

Mr. BURR of North Carolina. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, let me say that I hold in high regard my colleagues on both sides of the aisle that are here on different sides of this debate.

I hope the fact that we have seen the works of political satirists and comics is not an indication that health care policy in this institution will be driven by the jokes that we see in the newspapers but that it will be driven by the policies that we should adopt about those real people.

Mr. Chairman, I think that the forgotten folks in this debate are the 200-plus million people that are insured, many of whom are happy with the system. You know, we do have the best health care delivery system in the world, and I hope that that is not something that would be challenged on this floor. It is not a system that we want to change the gold standard that we have set. Nor is ours a system where the American people want to wait for procedures, like they do in other countries.

I am confident that it is, in fact, the wish of the American people that Congress do no harm to the system. Is there room for improvement? There always is. I remember when I became a Member of Congress, I took the same health care coverage that I had in North Carolina, only to find out that the cost of it was some $30 higher than the 50-person company I worked for. It was, needless to say, something that I had to inquire as to why.

That health care company said to me, ''Richard, never let the Federal Government negotiate your health care.'' That stuck with me ever since then, because it gets at the heart of cost, and it also gets at the heart of the quality of the services provided.

I am hopeful that through this debate we can separate the rhetoric and the policy and truly come up with the right direction.

Mr. BROWN of Ohio. Mr. Chairman, I yield 2 minutes to the gentleman from Massachusetts (Mr. MARKEY), a member of the committee.

Mr. MARKEY. Mr. Chairman, back 4 years ago the gentleman from Iowa (Mr. GANSKE) and I introduced a gag bill, a bill that said that physicians should not be gagged in telling a patient that they might need some additional help, some additional services outside of the scope of what the HMO might want to provide. We had 169 cosponsors on our bill in the 104th Congress. We had 302 cosponsors on that bill in the last Congress, but the Speaker of the House would not allow us to debate it out here on the floor of Congress.

We have come a long way since that point, not that long ago, when that was controversial in the minds of the majority, of the Speaker, a gag rule.

The gentleman from Iowa (Mr. GANSKE) and I are looking back at that as though it is ancient history, because this debate has moved far beyond that now. The majority wishes they could just work on the gag rule now, ''How do we go just on that?'' But that issue is passed by, and as each issue goes to the public and they understand it more, the Republicans get educated more.

Now we are down to the question of whether or not, if an HMO engages in practices which are really wrong, that an injured family should be able to sue,

to say something went wrong; my family member got hurt. The public understands this issue. It is 75–25. ''Give me and my family the right to be able to protect ourselves. Allow me to be able to sue someone who harmed my family member.''

They are debating on this final issue now, but it is going to go in. If it does not go in this Congress, it is going in the next Congress. And you should view that gag rule as past being prologue. Vote for this substitute today, and give the American people what they need, protections for their families today across our country.

Mr. BURR of North Carolina. Mr. Chairman, I am pleased to yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Chairman, when we come to the well of the House to speak, we can make speeches about the things that divide us. And we can do that for partisan reasons or other reasons. Or we can choose to come and talk about the things that unite us and then try to examine our differences. We are, in fact, united within the Republican Party and among Republicans and Democrats on most of what will be debated today and most of what will be debated tomorrow.

We all understand that managed care has brought us savings, but it has also put insurance companies between doctors and patients, and that is not good.

All of us, all of the plans, all four of them that will be debated agree on that and have good provisions to protect patients. We are not fighting about that. What we do have a legitimate difference of opinion about is the extent to which patients ought to be able to sue their insurance companies. That is a legitimate difference.

In fact, three of the four versions that we will vote on, two Republican and one Democrat version, will allow patients to sue their insurance companies if they have been harmed by them, so we are not even fighting about that. The one plan that does not allow suits, as everybody knows, that is going to fail and get the least number of votes of all of them.

So now the whole debate about which people will try to make political hay for reasons of elections is really about what is the best structure to allow patients to get accountability and to get redress when they are really hurt, which does not create a feeding frenzy for the trial bar. That is what this is about.

The gentleman from Georgia (Mr. NORWOOD), whom I respect immensely, a good friend of mine, has one version. Our bill, which we now call Goss-Coburn-Shadegg-Greenwood, et cetera, has another version, and the gentleman from South Carolina (Mr. GRAHAM) has yet another version.

We are going to have a good debate for the next two days. And if we can stop trying to make political hay out of it and try to figure out what is good for the American people, I have a feeling that this House will pick the right and wise position.

I advocate for the position that the gentleman from Colorado (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) and I and the gentleman from Florida (Mr. GOSS) have structured. We think it is the midpoint. We think it allows accountability, unlike the Boehner proposal, but it does not allow wide open accountability, which we think would generate too many lawsuits, which would then be settled by the insurance companies day in and day out, raise the cost of insurance, and cause employers to stop offering insurance to their employees because the cost is high.

So we think that our version, the Goss-Coburn-Shadegg-Greenwood substitute, strikes the midpoint, and I would urge all of my colleagues to support us in that position.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from New Jersey (Mr. PALLONE), who worked incredibly long hours in support of this legislation.

Mr. PALLONE. Mr. Chairman, I have great respect for the previous speaker, the gentleman from Pennsylvania, but I think he suggests that somehow there are not great differences between these various bills. And I do not think that is true.

There are two goals in the Norwood-Dingell bill, and each of the other substitutes that we are going to vote on tomorrow takes away from those goals I think in a significant way. And that is why Members should vote for Norwood-Dingell and not any of the other three substitutes.

Those two goals, which I have spoken about many times in the well, are as follows:

One is the issue of medical necessity. The bottom line is the decision of what kind of care you get, whether you get a particular operation or procedure, whether you can stay in the hospital a certain number of days. That basically is defined by what is medically necessary.

What the Norwood-Dingell bill says is that that decision, what kind of care you get, what is medically necessary, is going to be made by doctors and by the patients and not by the HMOs, not by the insurance companies.

The second goal in the Norwood-Dingell bill is to enforce your rights. If that decision about what kind of care you make goes the wrong way, you should be able to go either through an independent review board or through the courts, if necessary, in order to enforce your right. It is an enforcement issue.

The bottom line is that the Norwood-Dingell bill provides for a very good enforcement mechanism. It says that when you want to appeal a decision because of a denial of care, you are going to go to an independent review board, not under the authority, if you will, of the HMO. And they are going to define what is medically necessary, what kind of care you get, and they can overturn a denial of care. Failing that, you can go to court.

All of the substitutes take away from those two goals, and that is why you should vote against the substitutes and vote for Norwood-Dingell.

Mr. NORWOOD. Mr. Chairman, it is now my great pleasure and honor to yield 2 minutes to the gentlewoman from New Jersey (Mrs. ROUKEMA).

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Chairman, I want to say this is really wonderful. I want to congratulate the gentleman from Georgia (Mr. NORWOOD), the gentleman from Iowa (Mr. GANSKE), the gentleman from Michigan (Mr. DINGELL), and all of the others who cosponsored this legislation, because we are finally getting past bureaucrats and HMOs practicing bottom line medicine.

□ 1815

We are putting the medical decisions back in the hands of the medical professionals, where they belong. I think that has been more than adequately explained by those who have come before me.

I guess I have to recognize that there has been another straw man put up here, and misinformation on lawsuits and so forth, in that somehow this legislation is an open door to the courthouse. That is not true. That is not on the facts. There are strict appeals processes, strict grievance procedures, and lawsuits are only the last resort.

Mr. Chairman, I guess I also have to say that I had an interesting conversation with a host of a radio show the other day that I think more than anything explains why this provision for appeals process and Federal and State court access to the legal liability is necessary.

This was a Christian radio station. They were interviewing me. The host was a conservative-oriented host, okay? We discussed a number of things. All of a sudden he says, Congresswoman, you know what, a builder who built my house, we closed on the house and I thought I had a good contract with him. I thought everything was well explained. But I no sooner moved into the house than the foundation was weak, the roof leaked, I had to replace the roof, and by God, he was refusing to deal with it, Congresswoman. Of course, I went to court.

Would you tell me that if my mother died because of a denial of treatment by an HMO, that I should not have the ability to go to court?

Mr. Chairman, knowing that these procedures are very specific, can we really say to our constituents, conservatives and liberals alike and everybody in between, no, you cannot file a grievance procedure when your mother died, but you can take your homebuilder to court?

Mr. Chairman, last year, the House conducted a similar debate on the future of health

coverage for working Americans—an issue of critical importance for every family in our Congressional Districts. At that time, I stood on this floor and asked, ''Is this as good as it gets?''

The answer last year was a disappointing ''no.''

But 1999 may be different. The debate over who makes medical decisions for our family members—doctors or insurance company bureaucrats practicing ''bottom line medicine''—has moved forward significantly.

Today, after this debate, the House will vote on no less than three pieces of legislation that protect a patient's access to necessary medical services AND ensure a patient's right to hold health plans responsible for their treatment decisions.

All three have been drafted by Republican Members of this House and all three move the public policy debate in the right direction. This is a victory for families everywhere.

So, ''Is this as good as it gets.''

Well, if this House passes the Norwood measure then the answer will be yes. The Norwood bill, which I am a proud co-sponsor, includes many significant improvements in Patient Protections. It includes:

Emergency Services.—The bill says that individuals must have access to emergency care, without prior authorization, and under a ''prudent layperson'' standard.

Direct Access to ob/gyn care and services, including direct access to all covered obstetric and gynecological care, including follow up care and direct access to a broad array of qualified health professionals for ob/gyn care.

Direct Access to Pediatric Care by ensuring access to appropriate specialists for children and pediatricians as primary care providers. The list goes on.

But let's face it—the crux of this debate is about one issue—protecting a patient's ability to hold HMOs accountable for any negligent actions—the ability for patients to sue.

But an important point must be understood here. This legislation is not an open door to the courthouse. The bill contains a strict grievance procedure if a plan denies a claim, including a legally binding independent external review done by a panel of medical specialists. If a plan does not follow the recommendation of the grievance procedure than the patient may seek judicial relief in state court. Since the external review language is so prescriptive, most claims should be taken care of at this level, rather than the courthouse. This bill reduces the need for costly court cases by setting up a straightforward appeals process for grievances.

Lawsuits Are the Last Resort.—The bill only allows suits for personal injury or wrongful death and this greatly limits the type of suits that can be filed under the bill. The bill does not allow suits and damages for persons who weren't harmed and does not allow suits and damages for benefits that weren't covered by the plan.

Employers Are Protected.—Much has been said that opening plans up to liability will trap small businesses in a swamp of litigation that will eventually force them out of business.

Well let's set the record straight. Small employers usually contract out with insurance companies to administer the health plans, thus these small employers don't exercise discretionary authority. In an explicit provision in the Norwood bill, only employers who exercise discretionary authority (i.e., make medical decisions/pre-certification and utilization review) can be held liable along with the health plan.

So, Mr. and Mrs. Small Business, unless you are at the table with your insurance company bureaucrats using discretionary authority to design your own health plan, you are shielded from liability. So the claim that you will be sued out-of-business simply does not hold water.

Mr. Chairman, I don't know if this is as good as it gets, but it is better than last year and a world of difference from current law where insurance company clerks and accountants are making medical decisions about our loved ones.

Support the Norwood bill.

Mr. BURR of North Carolina. Mr. Chairman, it is my honor to yield 1 minute to the gentleman from Florida (Mr. MCCOLLUM).

(Mr. MCCOLLUM asked and was given permission to revise and extend his remarks.)

Mr. MCCOLLUM. Mr. Chairman, well-intentioned HMOs have run amok, and tomorrow we are going to have an opportunity to correct some of the more glaring deficiencies and to allow more choice, more right to choose the doctor you want, and for doctors to get more control over their patients' care.

The principal bone of contention we have in this legislation and the choices we have is over the decision-making with regard to redress and negligence, when that occurs in the HMO circumstance. Norwood-Dingell allows tort claims in State courts as the last resort, but fails to require the exhaustion of administrative remedies before administration, and contains no caps on damages that can be awarded. It also leaves open the possibility of employer liability, not just HMO liability.

On the other hand, Coburn-Shadegg requires the exhaustion of all administrative remedies before litigation when relief is sought, but the right to seek court relief is too narrow, and suits are required to be brought in Federal courts, which are already overworked, and simply an inappropriate place for dumping this garden variety type of litigation.

I hope that tomorrow we send a strong message and pass an appropriate Patients' Bill of Rights, but work out these problems in conference, because once the House-Senate meets to bring back a bill to us, it needs to be right. We need to have the exhaustion of remedies. We also need to have the remedy.

Mr. NORWOOD. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, dead people really should not have to go to external review. Of course we exhaust all administrative remedies, unless there is bodily harm or death which occurs before you get to external review. If you do not do that, we encourage those people to drag it out forever until someone can die.

Mr. Chairman, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from Massachusetts (Mr. TIERNEY).

Mr. TIERNEY. Mr. Chairman, I thank the gentleman from Ohio for yielding time to me.

Mr. Chairman, in 1994 the insured population was swelling while the cost of health care was rising higher and higher, even higher than the rate of inflation. We were paying more and getting less, but we backed off and walked away from health care reform because we were told there really was no health care crisis.

Yet, when we look at the picture now, things have only gotten worse. The Census Bureau tells us that the number of uninsured continues to rise. Health care costs are still escalating, and the Federal employees' health benefit premiums are going to 9 percent this year. The managed care organizations who were supposed to solve the problem of cost have not only failed to do so, but have added new problems of their own.

The system is still in need of major reform that would make health care universal and that would eliminate the inhumaneness of our current system, which leaves millions without coverage. But in the meantime, even our imperfect system has things that can be improved.

Managed care should not be allowed to run rampant over patients by denying emergency care arbitrarily, by interfering with doctors' professional clinical judgments, and by injuring patients who have no legal redress.

Only the Norwood-Dingell bill allows access to lifesaving clinical trials and prescription drugs outside the plan-defined formulary. Only the Norwood-Dingell bill has whistle-blower protections for doctors and nurses who advocate for patients. Only the Norwood-Dingell prohibits plans from giving financial rewards to health care professionals when they limit care. Only this bill will hold plans accountable through strong external review processes, backed by a nonwaivable right to sue in court, as people should have.

When we buy health coverage, what we really are purchasing is peace of mind and the security that we will be taken care of in the event that something unforeseen occurs. Without some way of holding plans accountable to what they have promised, we can never be certain that our care will not be denied. We have to support the Norwood-Dingell bill.

Mr. BURR of North Carolina. Mr. Chairman, it is my pleasure to yield 3 minutes to the gentleman from Arizona (Mr. KOLBE).

Mr. KOLBE. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I think the significance of today's debate cannot really be overestimated. This legislation and the many permutations that we are considering is going to affect the lives of 160 million working Americans, every small business owner, every self-employed person, every corporation in America. The decision that we make here today and tomorrow has the potential to fundamentally alter the

structure of the U.S. health care system, and with it, the quality and the quantity of health care that every American enjoys.

The task that we have before us today and tomorrow is to strike a balance between assuring access to health care and assuring accountability for those who provide it. We have to rise above the rhetoric, the heated rhetoric, which we are going to hear in these next 2 days and find the truth. If we do not and we respond with knee-jerk legislation, that in the end will only cause more harm than good to patients.

Let us be honest, there are no easy answers in this debate, but we can begin by acknowledging that under current laws, HMOs are not held truly accountable for their health care decisions. When the agent responsible for delivering health care services is the same agent that is responsible for controlling costs, then the quality of health care gets short-changed, and rationing of care results.

I have heard the cries of people in Arizona, and I have listened to the angry complaints of physicians who serve them. I have heard the horror stories I know many of my colleagues have about cancers that went untreated, physical deformities that went uncorrected, lifesaving therapies that were denied.

I believe HMOs should be held accountable for their decisions. But unfortunately, the suggested remedy in the underlying Norwood-Dingell bill establishing the unlimited right to sue an HMO I find equally troublesome. Already 44 million Americans have no health insurance, and that number is rising. Another significant number of Americans are underinsured. There can be no doubt that permitting unlimited liability will increase both the cost of health insurance and the number of uninsured.

How do I say this? How do I know that I can say this? In the first instance, simple economic logic tells us that insurers will pass the cost of increased risk of litigation along to someone else, and that someone in this case is going to be the consumer.

We have plenty of empirical evidence about the second concern, the loss of coverage for working people. I have in my office dozens of letters from companies in my area that say, in effect, any expansion of liability will force us to drop health insurance for our employees. The reason is straightforward. A company always seeks to reduce unknown and unquantifiable business risks. Norwood-Dingell is an open-ended liability, a brand new lottery for trial lawyers.

I am concerned that instead of 44 million uninsured Americans, we should all worry that in 4 or 5 years, with unlimited right to sue, the ranks of uninsured Americans will swell to 144 million people. That is what I mean by a knee-jerk response to a very ugly problem.

I urge my colleagues to reject the Norwood-Dingell bill and to support the Coburn-Shadegg bill.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Chairman, every day I hear from my constituents enrolled in HMOs who are crying out for help.

Most Americans want guaranteed access to emergency room care, and so do I. Most Americans want to be able to see doctors who are specialists, and so do I. Most Americans want the ability to choose their own doctors, and so do I. Most Americans want doctors, not accountants or bureaucrats, to make decisions about their medical health care. So do I. Most Americans want protection of the doctor-patient relationship. So do I. Most Americans want the ability to sue their HMOs if they are injured by deficient medical care, and so do I.

It is ludicrous that in New York City if you were injured in a taxicab, you can sue, but if you are injured or killed by deficient medical care, you would have no right to sue. That cannot continue to happen in the United States.

The Norwood-Dingell bipartisan bill is the only one which guarantees these consumer rights. It is the only one which will ensure that Americans will have quality health care. It is the only one that will ensure that Americans who understand the needs of health care get access to quality health care.

I commend the gentleman from Georgia (Mr. NORWOOD) for his courageous stand, and the gentleman from Michigan (Mr. DINGELL) as well. Americans will not be fooled. Americans want quality health care. So do I. Support Norwood-Dingell. It is the only bill that assures them that quality.

Mr. BURR of North Carolina. Mr. Chairman, I yield myself 1 minute.

Mr. Chairman, I want to tell a quick story about a town in North Carolina in my district, a town with a high concentration of textile workers and companies, companies that are forced to compete on margin, struggling to find cost-effective health care for their employees.

They banded together and self-insured. They supplied a greater benefit package to their employees than they ever could have had they gone through an insurance company. Their creative, innovative approach to quality health care for their employees is in jeopardy with what we do here in the next 48 hours, because if we extend liability to those employers, they will no longer offer health care as a benefit.

For us to talk about the human face hopefully is not to show that face of the future uninsured because of our actions. I would encourage my colleagues to vote against the Norwood-Dingell bill and to support the Coburn-Shadegg bill.

Mr. Chairman, I yield 2 minutes to the gentleman from Arizona (Mr. SHADEGG).

(Mr. SHADEGG asked and was given permission to revise and extend his remarks.)

Mr. SHADEGG. Mr. Chairman, I rise in strong support of the Goss-Coburn-Shadegg-Greenwood alternative substitute, but I want to begin by talking about the Norwood-Dingell bill and about what it does.

I want to talk about the fact that it simply goes too far. When we look at the legislation, it makes liability too available and it turns the entire system over to the lawyers.

I want to focus in my remarks particularly on an issue that concerns the employers in my district. That is, can those employers be held liable when all they do is buy insurance for their employees. The reality is, the sad truth, is that my good friend, the gentleman from Georgia (Mr. NORWOOD) wrote language which he thought protected employers, but which does not do so. It says quite clearly that if an employer exercises discretionary authority, that employer may be sued.

□ 1830

Discretionary authority is a very broad concept. Indeed, the decision not to do something can be construed as the exercise of discretionary authority. I want to contrast that with our efforts to protect employers. We said, no, we should not make employers liable. We ought to make health care plans liable.

So how can we do that? Because we want employers to pick a health care coverage plan. So we wrote that employers cannot be sued for picking a health care coverage plan. We want employers to participate on behalf of their employees. We want them to be able to advocate on behalf of their employees. That is the exercise of their discretion. We want to them to be able to make a decision not to advocate an employee in a particular case without being suable for just that decision.

Let us look at the language in our substitute. It does not say if one really exercises discretion as an employer one can be sued. It says that one may only be sued if one chooses as an employer to directly participate in the final decision to deny care to a specific participant on a claim for covered benefits.

We had written an airtight provision that says one cannot sue employers. We did it precisely because we want employers to pick a plan. We want them to offer health care coverage. We want them to get involved and advocate on behalf of their employees. All of those are the exercise of discretion.

Sadly, the Norwood-Dingell bill allows suits by anyone. One does not have to show actual harm or does not have to be sustained by a panel like ours does. One can sue at any time. There is no requirement that one goes through administrative remedies.

One can sue over everything. Ours is limited to just covered benefits. One can sue even when the plan does everything right, that is, the plan makes the right decision that is sustained on external appeal. One still can sue under

the Norwood-Dingell bill. Sadly, they put in place no limits.

I know that doctors across America do not like the fact that they can be sued; and in some States, there is no tort reform. We need tort reform. We do not need lawsuit lotteries against doctors, but we also do not need them against plans driving up costs and driving patients away from the system because they cannot get coverage.

Mr. NORWOOD. Mr. Chairman, it is my pleasure to yield 1 minute to the gentleman from New Jersey (Mr. FRELINGHUYSEN).

(Mr. FRELINGHUYSEN asked and was given permission to revise and extend his remarks.)

Mr. FRELINGHUYSEN. Mr. Chairman, I thank the gentleman from Georgia for yielding me this time.

Mr. Chairman, judging by the amount of time and money that some Washington lobbyists are spending on character assassinations and other ridiculous paraphernalia that we have received in our office in an attempt to defeat the Norwood-Ganske-Dingell bill, I am more certain than ever of supporting this bill.

This bill deserves our bipartisan support. This bill is right on target. It puts patients first. That is what we are here for, for our constituents. I support the Norwood-Dingell-Ganske bill.

Mr. Chairman, judging by the amount of time and money some Washington lobbyists have spent in recent weeks on character assassinations and other ridiculous paraphernalia in an attempt to defeat this bill, I am more certain than ever that voting for this bill is the right thing to do.

The Norwood-Dingell-Ganske bill is the only legislation that puts patients—our constituents—first!

We've all heard that question posed, ''is there a doctor in the House?'' when someone is in dire need of expert medical care. One always hopes that someone with some sort of medical training is nearby to assist. Well, Mr. Chairman, we must pose that question here today: Is there a doctor in the House?

As my colleagues are already well aware, indeed there are physicians in our Congressional ranks—bona fide caregivers, medical experts, right here among us. Because we are in need—because the American public is in dire need of expert medical advice—we ought to listen to the professionals among us.

Why is it that ''the doctors in this House'' support legislation with stronger patient protections?

Because they have been on the front lines of this debate—they have been there to see the look in the eyes of a mother who discovers her health plan won't cover the next phase of her child's cancer therapy.

They've been there when an insurance company accountant dictates to them what medical options are available and what essential information cannot be disclosed to their patients.

Mr. Chairman, patients, men, women, and children and their families rely on doctors in life and death situations, a heavy responsibility. But that resonsiblity is even greater under our current managed care system as insurance companies burden doctors with making medical decisions that too often coincide with the company's business decisions.

Mr. Chairman, our nation's doctors went to medical school because they were passionate about helping people. They could have gone to business school if they were interested in helping companies make a profit.

And Mr. Chairman, Americans want to be assured that when they step into their doctor's office, they will be seen by a doctor, not an accountant!

Realizing that managed care is here to stay, and that health maintenance organizations will always be in the business of making a profit as much as they are in the business of keeping patients healthy, we must not miss the opportunity to strengthen the system and make it more accountable. We must bring balance to the system—balance that ensues doctors are free to provide compassionate care to their patients, balance that ensures doctors are free to provide compassionate care to their patients, balance that ensures providers are protected, too, yet held acountable when a decision ultimately proves wrong, and balance that, most importantly, assures patients that they are the number one priority for their health care provides.

We can do that by passing H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act of 1999 of which I am a proud co-sponsor. The Bipartisan Consensus bill provides important choices for everyone—the most important being the passage of a law that provides for the best health care possible in the next century.

The Bipartisan Consensus bill provides access, accountability and strong patient protections. It also: gives patients the ability to appeal a decision by their health plan; won't allow health plans to prevent doctors from informing their patients of all treatment options; gives female patients direct access to OB/GYN care and services, and children direct access to pediatricians; provides all patients with access to emergency services; and ensures that medical decision makers would be held responsible if someone suffers injury or dies as a direct result of that decision.

With just these few simple provisions, this legislation would eliminate some of the most egregious and unfair abuses by some health insurers.

Mr. Chairman, in the year or so since our last attempt to reform managed care, nothing has improved. In fact it has only gotten worse as we learned earlier this week of reports that said another one million people have joined the ranks of America's uninsured. This is a startling revelation considering our robust economy.

If this bill is defeated, another year will go by, maybe more time, and we will start the 21st century having missed an opportunity to provide Americans with the right to control their own health care. Indeed, we are afforded a rare opportunity here to prove to an already cynical American public that when the United States Congress debates the bottom line in managed care reform, we refer to protecting people, not profits.

Mr. Chairman, in closing, I remind some of my colleagues that no one political party owns this issue. All of us have heard from our constituents who tell us about their unhappy experiences with their health plans. I think it is the desire of every member to make health maintenance organizations more accountable—no one is interested in promoting more litigation; we simply support basic protections for all Americans.

As the greatest nation in the world counts down the days until the start of a new—millennium—there is no better way to prepare for a strong, healthy America than by putting people in control of their health care. Let's pass the Bipartisan Consensus bill (H.R. 2723), and let's return medical decisions to doctors and their patients.

Mr. BROWN of Ohio. Mr. Chairman, I yield 1½ minutes to the gentleman from New Jersey (Mr. ANDREWS).

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Mr. Chairman, I thank the gentleman from Ohio for yielding me this time.

Mr. Chairman, I rise in strong support of the Norwood-Dingell-Ganske bill and in opposition to the other substitutes. I believe it is important to point out the strengths that the real Patients' Bill of Rights, the Norwood-Dingell-Ganske bill, has. There are two of them.

The first is that the key aspect of liability is not simply the claims on which people can prevail in court and make their specific case winnable. It is the behavioral change that liability will introduce throughout the managed care system. It is a decision that will be made with people understanding that there are real consequences.

The key to the Norwood-Dingell bill is not the suits that will be brought. It is the suits that will not be brought because the right decisions will be made in the first place.

The second advantage of this bill is its medical necessity standard. It is very important for us to lay out very clearly, as the Norwood-Dingell bill does, that disputes will be resolved under an objective standard of medical necessity defined by the best practices of those who practice in a given medical field, not by the arbitrary economic discretion of the insurance carrier.

For reasons of medical necessity and the benefits of liability on corporate behavior, it is important that we reject the other substitutes and strongly support the Norwood-Dingell-Ganske bill.

Mr. NORWOOD. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, however one views this debate, it is exciting. Think about where we have come in 5 years. I mean, here we are, all members of the Committee on Commerce. All of us know each other well. We are generally good friends. The gentleman from Oklahoma (Mr. COBURN) and I do not disagree on probably three things on this Earth.

We are actually sitting here all talking about the same thing. We are talking about a managed care system, Mr. Chairman, that has gone awry, where it allows people to practice medicine who simply are not licensed to do so. Even if they are licensed to do so, usually it is a dermatologist telling a cardiologist how to treat their patient; and they are 2,000 miles away, looking at a computer screen. They have never touched that patient. They have never listened to their heart. They have never listened to their lungs. They are 2,000 miles away, and they say, Doctor, you cannot possibly be right. I know better. I have got a protocol in front of me. That is what we have allowed to happen in this country.

Now, have some people been killed? You bet. Why do my colleagues think the insurance industry said to Congress in 1974, give us the system. We will manage the costs. We will make it cost cheaper. By the way, we are going to have to deny some benefits to do that. We are going to kill a few people. For God's sakes, give us immunity, too. And we did. They are the only industry in America where we say they are absolutely protected from being responsible for their actions.

We do not believe that. We tell everybody they need to be responsible for their actions, do we not? We tell welfare mothers. We tell deadbeat dads. We tell teachers. We tell everybody. One has to be responsible for oneself. When one harms somebody, one has got to step up to the plate.

Do I want anybody sued? No. I am not interested in lawsuits, and I never have been. But the people who are practicing medicine without a license are being paid to do so. They are incentivized to do so. They lose their job if they do not do it.

Do I want a hammer over their head? Yes. Do I want that insurance clerk to think twice when he says to that mother, I know the pediatrician thinks your child needs to be hospitalized, but I know better. I have got it on my computer right here. I want that clerk to think twice about it.

If that clerk makes a decision that denies a benefit that is in a plan and causes death or injury, then, by golly, maybe we should go to court on that. We ought to go to State court. I strongly believe that now.

A lot of us do not disagree on a lot of this. We do disagree a little bit on the liability. I want to just tell my colleagues that, in our bill, employers who do not make medical decisions cannot be held liable on H.R. 2723. It states that a cause of action may only be filed against an employer when the employer exercises discretionary authority to make a decision on a claim for benefits covered under the plan and the exercise of such authority results in injury or death.

What that means is that the employer has the ability to make some decisions. If one of those decisions it makes is a medical decision, if it absolutely denies one of the patients a benefit that is in their plan, and they die from it, yes, we are saying the employer needs to be responsible for that and needs to be called up.

The only system of justice we have in this country, where does one right a wrong if one does not do it in a courtroom anymore? We are not going back to the O.K. Corral. We are not going back to six guns to solve our problems.

We have only one system of justice; and to say to an entire industry in this country, no, they never have to be held accountable for the decisions that they make, even though the Congress of the United States told them they could do all of this, discretionary authority does not include an employer's decision to include or exclude from the plan any specific benefit. What that says, they can have anything in it that they want to.

Now, we agree on a lot of things, but the one thing that is a must, my colleagues must vote for the bipartisan bill if they want to protect patients because that is how we get to a law.

Mr. BURR of North Carolina. Mr. Chairman, I yield 3 minutes to the gentleman from Oklahoma (Mr. COBURN), still a practicing doctor.

Mr. COBURN. Mr. Chairman, I love the gentleman from Georgia (Mr. NORWOOD). What he just expressed to my colleagues in his heart is right. The conclusion he has drawn on how we accomplish what he wants to accomplish is dead wrong.

Let us just use their definition of protecting employers. I happen to have a son-in-law that is a lawyer. He likes their bill because he knows he is going to make a lot of money off of it, because the very subtleties of going to State court to solve the problem that the gentleman from Georgia (Mr. NORWOOD) so eloquently just described, which we all want to solve, we all want to solve that, says that that lawyer is going to file a suit against that company, not because he thinks he can and not because he thinks he will win, because that is the person with the deep pockets. Then he is going to work hard, and then he is going to extort, and he is going to say I am going to settle.

They do not care about the patients most of the time. What they care about are their pocketbooks. The reason we are in this shape is too many doctors in this country care about their pocketbook more than doctors in the first place, or we would never have had HMOs, or we would never have had the abuses of HMOs.

So if my colleagues really care about patients, and if they really want a solution that will meet the needs of those patients and not the needs of the trial bar, then we have to back up. We have gone too far. We have created a system that is going to result in the extortion of dollars from every employer in this country.

Mark my words, those guys are smart. They are going to find every crack every time. They are going to claim it under doing something good. But the motive is not going to be pure; the motive is going to be money. Just like the motive today with too many HMOs is money. It is not about patients to either side, but it should be about patients to this body.

The only way we have to fix it is with a middle ground that protects the very supplier of that care in the first place, does not undermine it, does not cut it. If they truly make a medical decision under the Coburn-Shadegg bill, they are held liable. They cannot be penetrated unless they are not. So let us hold them accountable. Let us do it in a way.

Let us get a good bill to the Senate. Let us get a good a bill that the President is going to sign. Let us fix the problem. Let us reverse the cynicism of this body. Let us talk about patients and not politics.

The CHAIRMAN. All time has expired for the Committee on Commerce.

Under the rule, the gentleman from Pennsylvania (Mr. GOODLING) and the gentleman from Missouri (Mr. CLAY) each will control 30 minutes.

The Chair recognizes the gentleman from Pennsylvania (Mr. GOODLING).

Mr. GOODLING. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, over the last several years, the Committee on Education and the Workforce has tackled the issue that should be number one when we talk about health care problems in this country, because the number one issue that needs to be fixed before anything else is the fact that we have 44 million uninsured people in this country, most of which work or have someone in the family that works.

That is very, very expensive to health care because, of course, the cost shifting that takes place is dramatic. Someone has to pay for the bills for the uninsured.

So today we have an opportunity to make a real difference in the lives of many Americans. As I said to the committee over and over again, there is a very fine line. Our job is to make sure the 44 million get insured and at the same time make sure that the 125 million do not get uninsured that are already insured.

We can thoughtfully provide real patient protections, including a binding external review by independent medical experts, that will ensure that Americans who currently have health care coverage get the care they are entitled to when they need it.

Unfortunately, we also have an opportunity to do great damage to a very successful system of employer-sponsored health care coverage and add to the ranks of the 44 million Americans who are presently uninsured. I would hope that we would make the wise choice.

□ 1845

One of the great casualties of this debate has been the reputation of one of

the most successful Federal laws ever enacted: The Employee Retirement Income Security Act, better known as ERISA. Enacted in 1974, ERISA has provided the foundation for employers to voluntarily offer health care insurance to their employees. It has given employers who operate in multiple States the ability to provide uniform benefits and administration to their health plans. This has resulted in more than 125 million Americans having coverage through their employers.

In 1998, more than 2 billion claims were filed under employer-sponsored health plans. The overwhelming majority of these claims were approved and participants and providers were reimbursed in a timely fashion. Because some small percentage of these claims are disputed or denied, some Members of this body believe that litigation and trial lawyers are the best way to bring about accountability.

But what if we could guarantee that any benefit disputes could be resolved by an independent panel of medical experts in a time frame that takes into account a patient's condition, and then, if warranted, provides care immediately, not a courtroom, which finally makes a decision after they have died. What need would anyone have for courts and lawyers? The answer is none. And that, frankly, is what so upsets supporters of H.R. 2723. They put their entire faith in the hands of lawyers and courts that are blind to a process that would ensure proper medical care without the need of litigation.

The various bills that we consider today, all of them, and tomorrow, have all of the patient protections that are needed. All of us have the right for women to have direct access to OB–GYNs; the right for parents to designate a pediatrician as a primary care physician for their children; the right for unrestricted communication between a doctor and a patient. They all have these. The right to seek care if a person reasonably believes they are in an emergency situation; the requirement for greater disclosure of information from health plans and that the information be communicated in easy-to-understand language. They all have continuity of care for pregnant mothers, those awaiting surgery, and the terminally ill. And they all have access to specialists and the right to go to doctors outside a closed network.

What has become the focal point of the debate is whether we provide a system that guarantees quality medical care or begins a new era of expensive, lengthy, and self-defeating litigation. The Dingell-Norwood bill, I believe, would quickly take us to a medical decision by court order. It would result in a significant increase in health care costs, and will, make no mistake about it, result in many more Americans joining their 44 million fellow Americans in the ranks of the uninsured. It is bad medicine and bad policy. All Members should think long and hard before they entrust the future of medical care to lawyers and courtrooms. Get them into hospital rooms when needed, not courtrooms.

I urge all Members to oppose expanded liability and support an approach that provides people with the care they need when they need it: binding external review of any disputed health care claim. A bill almost like that passed last year out of committee and on the floor of the House.

Mr. Chairman, I reserve the balance of my time.

Mr. CLAY. Mr. Chairman, I yield myself 2 minutes.

(Mr. CLAY asked and was given permission to revise and extend his remarks.)

Mr. CLAY. Mr. Chairman, during the past few years, health care consumers have expressed increasing concern about the manner in which managed care plans are operating. Patients are being denied emergency care. Patients are being denied access to specialists. Patients are being denied needed drugs, and patients are being denied the ability to hold plans accountable for these coverage denials. Clearly, Mr. Chairman, this situation is intolerable, and the enactment of Federal legislation is needed to remedy it.

Though several comprehensive managed plan reform bills have been introduced during this session of Congress, I first decided to cosponsor H.R. 358, the patients' bill of rights introduced by the gentleman from Michigan (Mr. DINGELL), because it would best deliver the comprehensive and enforceable patient protections that health care consumers demand.

In addition to the patients' bill of rights, I also decided to support the compromise now before us, introduced by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL). This bill retains all of the essential protections found in the patients' bill of rights. Among them are access to enforcement in State courts if an individual is injured by their health plan's actions and a fair and responsive grievance and appeals process.

Despite the initial attempts by the Republican leadership in both bodies to block consideration of the patients' bill of rights, those interested in real health care reform continued to fight for its consideration. Now, with H.R. 2723, we have a reasonable compromise that can become law. I urge a ''yes'' vote on H.R. 2723 and ''no'' votes on all three substitutes.

I would like to take this opportunity to briefly discuss the bogeyman known as ERISA. I have been on the primary committee of ERISA jurisdiction, which is now known as Education and the Workforce, for over 30 years and I have watched how this statute has been repeatedly misconstrued by the courts and employers.

First and foremost, ERISA, the Employee Retirement Income Security Act, was enacted in 1974 to protect the pension and other employee benefits promised to workers and their families. Plain and simple, ERISA was intended to protect workers, not be used against them.

ERISA was primarily directed at pension plans. It contains extensive standards that employers must comply with in order to ensure that workers receive promised benefits. With respect to health benefits, ERISA contained few standards. That was because Congress was already debating health care reform in 1974, and Congress expected to shortly enact national health care legislation. Unfortunately, that legislation never came to be.

ERISA contains two key provisions that have repeatedly been misinterpreted by the courts and used to undermine the employee benefit protections of ERISA. First, although ERISA permits individuals to sue for violations of the law, ERISA only permitted individuals to seek ''appropriate equitable relief.'' The reason for this was that pension law derives from trust law and under trust law equitable relief includes money damages. Unfortunately, the initial courts that interpreted ERISA did not consider ERISA's underlying trust law basis.

Second, ERISA preemption. ERISA did intend to preempt states from directly enacting laws that regulate benefit plans. But, ERISA specifically included a provision that permitted state laws that regulate insurance. Historically, health benefits have been provided through insurance companies and the states have always been the primary regulators of insurance. Unfortunately, here too, the courts misinterpreted ERISA and encroached upon traditional state authority. ERISA always intended for states to continue to be able to regulate the activities of insurance companies, which includes managed care companies.

Mr. Chairman, let's make ERISA what it was intended to be—a law to protect the pension and employee benefit rights of workers and their families.

Mr. Chairman, I reserve the balance of my time.

Mr. GOODLING. Mr. Chairman, I yield 5 minutes to the gentleman from Ohio (Mr. BOEHNER), a gentleman who truly cares about those who are uninsured and truly cares about those who need quick medical attention.

Mr. BOEHNER. Mr. Chairman, I thank the gentleman from Pennsylvania for yielding me this time; and I would like to follow up on his earlier remarks.

In America today, about 125 million lives are insured through employer-based plans. Earlier today, we passed an access bill that would give Americans more choice, give them an above-the-line tax deduction for health care that I think will empower them to have better choices in the system we have today and begin the process of developing a more competitive private market.

But the fact is today employers do, in fact, provide most of the health insurance that we have out there. I have letters in my office, one from Mike Toohey, a former staffer here in the Congress who now works for Ashland Oil, who wrote to me, and I will quote, ''Because I have leukemia, I am not insurable except through my corporate health care plan.'' Mike went on to say, ''My company's health care plan saved my life and paid for those costs.''

Employer-based health care is what made it possible for James Barton, a retired employee from Tulsa, Oklahoma, to get quality care for his wife after she had a stroke in 1998. He wrote and said, and I will quote, ''During the past year, my company's health plan has been a godsend,'' Mr. Barton wrote recently. ''We could not have gotten by without it.''

Employer-based health care is what made it possible for Simon Scott, a patient from Columbus, Ohio, to afford the expensive treatment he needed when he was gripped by cancer. He wrote, ''These choices were critical to me and allowed me to afford the medical care that I needed. Please oppose any legislation that will cause my costs and those of my company to rise at alarming rates, resulting in less coverage and less ability of my company to provide the quality care that I need.''

That is really what this debate is all about, Mr. Chairman. We have the underlying bill here, the Dingell-Norwood bill, and while the sponsors of the bill are dear friends of mine, and I would never question their judgment nor what their motives are because they believe strongly in the bill that they have before us, it is just that I and many Members believe it goes way, way too far.

Employer-provided health care in America today is a voluntary program, started back in the 1950s, then codified in the ERISA act that the gentleman from Pennsylvania (Mr. GOODLING) talked about earlier, that has allowed this program to grow successfully. But it is a voluntary program. If we put too much weight, if we put too much regulation, and, most importantly, if we put too much liability, we will drive employers away from offering this coverage to their employees. And when we look at the Dingell-Norwood bill, it does put the Federal Government more in charge of our health care by empowering the Secretary of Labor and the Department of Health and Human Services to look at health plans to make sure that they have network advocacy and all other types of Federal mandates.

Most importantly, and I think where we will see this debate go over the next day and a half or so, is in the area of lawsuits. Because under the Dingell-Norwood bill not only are health insurers and health care providers liable for insurance, but, in my view, employers are also subject to lawsuits. I do not believe we can sue our way to better health care in America today.

The sponsors will say they have shielded employers from any liability, and I will say that they have made an attempt to do that. But the fact of the matter is that under ERISA, employers have to provide discretion. And if they provide discretion under the Dingell-Norwood bill, they are now subject to liability.

I think there is another way, a better way to provide the care that Americans want, when they want it; and that is through a binding external appeals process that has severe penalties to make sure that employers and health care plans provide the care that the outside reviewers have determined that the patient ought to get. This independent review, this third-party review, has real binding teeth in it. It allows a reviewer to look at the care that is out there and available and would allow them to determine, within the contract, what appropriate care was right for that patient.

If the patient won the fight, they get the care. They do not have to wait around for a courtroom or wait around for a judge or a lawyer to get there. They get the care. And if the health plan or the employer drags their feet, it is a $1,000 a day penalty on that health plan or employer, with no cap. And if they willfully deny that coverage after it has been granted by an external reviewer, it is $5,000 a day, no cap. And while they are waiting, if they are dragging their feet, that individual has a certificate from an external reviewer that they can take and get their care at any medical facility they want to go to.

I think this is a much better way to provide the care that patients want without going to court. Let us do the right thing, the responsible thing and, at the same time, not undermine the employer-provided health care that millions and millions of Americans appreciate today.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Chairman, the managed care insurance industry has used the threat of lawsuits as a red herring in this debate. The insurance industry has chosen to use the oldest trick in the book to oppose the Norwood-Dingell bill, that is to say the problem is the lawyers. After all, no one likes lawyers, until they need one.

The insurance industry knows that the law in Texas, that the Norwood-Dingell bill is modeled after, has not resulted in litigation. In fact, I was a part of helping that legislation become law in Texas when it was first introduced in 1995. Since its enactment in 1997, we have had only five lawsuits filed.

In our Nation, there are two solemn principles guaranteed every person, rich or poor, wealthy or powerful, and even to the weak, and that is equal justice under the law and due process of law. Access to the courts ensures that every citizen, every business, every organization is accountable for their negligent actions. Only one group in our system of law is immune from litigation, and that is foreign diplomats. The insurance industry in this debate tonight wants to add one other group. That is the insurance companies themselves want to be immune from liability.

Now, no one wants to go to court, and the Norwood-Dingell bill has embraced a full internal and external review process to avoid having to go to court. But in the last analysis, the protections the American people deserve under our constitution is the right to have access to the courts.

The Congressional Budget Office estimated the cost of legal accountability would be 12 cents per month per patient. And the CBO says that half of that cost would be because the insurance companies would implement review standards to be sure that no patient is denied quality care. Sounds like a pretty good investment to me.

Every individual, every business understands that they are accountable for their negligent acts in our society; that they can land in court. Managed care insurance companies should be accountable too.

Support the Norwood-Dingell bill. It has worked in Texas, and it will work for all Americans.

Mr. CLAY. Mr. Chairman, I yield such time as he may consume to the gentleman from Indiana (Mr. VISCLOSKY).

(Mr. VISCLOSKY asked and was given permission to revise and extend his remarks.)

Mr. VISCLOSKY. Mr. Chairman, I rise in support of the Norwood-Dingell bipartisan consensus bill.

Ann is a 60-year-old diabetic from Lake Station, IN who had always taken care of her condition. She refused to drink or smoke, and carefully monitored her insulin and sugar levels. However, the disease continued to progress and her doctor scheduled regular kidney tests to make sure that her kidney function did not deteriorate to emergency levels. Then Ann switched to a Health Maintenance Organization (HMO), lured by promises of lower costs and prescription coverage. Her first primary care doctor continued the same regimen, keeping a close eye on her kidneys and monitoring her heart function and sugar levels as well. This doctor was dropped from the HMO. The new doctors she was allowed to see did not think regular testing was necessary. In fact, when Ann came down with an infected foot, a common symptom in diabetics whose condition is worsening, the approved doctors she visited were unmoved. Finally, a member of Ann's family realized she was in potential danger and took her to the emergency room. There she was found to be in congestive heart failure. She was also anemic and her kidney function had dropped to a dangerous level. The painful process of kidney dialysis became necessary. Several days later, Ann received a call from her HMO. Although her daughter had taken her to an approved hospital, neither the emergency room physician nor the two specialists she saw were on the approved list. Ann was forced to pay out of pocket for this emergency care.

Sadly, Ann's case is not unique. Certainly, many HMOs provide excellent medical care at a reasonable cost. However, there are far too many which routinely abuse their members, refuse to pay for necessary treatments, and, in many cases, prevent doctors from conducting treatments that they consider too costly.

Ann's story and others' from Northwest Indiana demonstrate just how desperately we need to reform the managed care industry. I

believe doctors and patients should make decisions about health care, not insurance company bureaucrats. That is why I support the Norwood-Dingell Bipartisan Consensus Bill.

Certainly not all HMOs abuse their patients, but there are far too many horror stories from real patients to think all HMOs act in a responsible and reasonable manner. The Norwood-Dingell bill will set a standard in which emergency room coverage is guaranteed as long as the prudent layperson considers the situation an emergency. Along with guaranteed emergency room care the Norwood-Dingell bill outlines common sense patient protections that provide access to specialty care, continuity of care, opportunities for patient grievances and appeals, and accountability for decisions made by HMOs regarding patient care.

This bill has the support of approximately 300 organizations, including the American Medical Association and the American Public Health Association. I am glad to see that the leadership of the House has finally addressed this important issue. I have been fighting to see that real HMO reforms be addressed in the House for the past three years. I am glad to see that we finally will be allowed a straight up or down vote on real HMO reform.

□ 1900

Mr. GOODLING. Mr. Chairman, I yield 3 minutes to the gentleman from North Carolina (Mr. BALLENGER), a member of the subcommittee.

Mr. BALLENGER. Mr. Chairman, I thank the gentleman from Pennsylvania (Mr. GOODLING) for yielding me the time.

Mr. Chairman, let me talk a minute about the 125 million people who could lose their insurance. H.R. 2723, or Norwood-Dingell contains language that would expose employers to lawsuits for voluntarily providing health care benefits to their employees and thus jeopardize the employer-based health care system.

The bill opens the flood gates for trial lawyers. It mandates greater cost and liability to employers of all sizes. Yet, defenders of this bill believe that employers would be shielded from liability unless they used discretionary authority on a benefit decision.

However, what is discretionary authority? In reality, nearly any health care decision made by employers entails the use of discretionary authority. This open-ended term leaves trial lawyers drooling over the possibility of litigation and employers considering whether to pull the plug on the health care benefits. Trial lawyers will continually test the term ''discretionary authority'' in the courts, which will cost employers millions in the realm of attorneys and defense.

An ad in today's Washington Post put it best. ''The patients' bill of rights is actually the lawyers' right to bill.'' When faced with the specter of liability and the ambiguous term ''discretionary authority,'' employers will opt to stop voluntarily offering health care and give employees the monetary equivalent. In a recent poll, 57 percent of small businesses said they would drop health care if faced with increased liability and cost.

We do not need more litigation spurred on by greedy trial lawyers. We need health care reform that supports both patients and the employers who voluntarily provide these important benefits. The solution is not liability but accountability, and the Boehner substitute does just that. This substitute strengthens the internal and external review process and holds health care plans liable for up to $5,000 a day if the plan refuses to adhere to the decision of the review process.

H.R. 2723 would jeopardize employer-based health care plans for over 120 million Americans. Support the Boehner substitute and let small businesses and employers continue to provide health care for the American workforce.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Chairman, I support Dingell-Norwood-Ganske because I believe the people have a right to decent health care in the United States of America. This is a life-and-death matter that transcends the narrow needs of insurance companies.

Do my colleagues know that the total cash compensation received by the CEOs of just the largest three HMO companies totaled $33.3 million. The insurance companies have enslaved our health system. They hold patients and doctors captive. They operate a modern-day plantation where servitude to their profit is their only objective.

The old spiritual says, ''Let my people go. Go tell it on the mountain.'' Well, we are here on Capitol Hill, and it is time to send a message to the insurance companies: let my people go. My people are being denied decent health care because of the insurance companies' profit motives. My people are being denied the doctor of their choice because of the insurance companies' profit motives. Let my people go.

My people are being charged confiscatory prices for prescription drugs. Let my people go. My people are being told they should not even have legal help in dealing with these same insurance companies because the insurance companies' profit motive is there.

The insurance companies may rule health care like modern-day pharoahs, but soon they will have to meet the awesome wrath of the American people. If we are worthy of the promise of government of the people, by the people, and for the people, we will free our people from the rule of the insurance companies, we will lead them out of this valley of tears to better health care, we will let them live longer, better healthier lives, let their children grow up healthy.

We have a chance to write a new chapter in this country's history where government of the people means better health care. Pass Dingell-Norwood-Ganske.

Mr. GOODLING. Mr. Chairman, I yield 30 seconds to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Chairman, I think the point here is that if we allow open-ended litigation in health plans what will happen is employers will let their people go, employers will let their people go without insurance because they will no longer be able to afford it.

The idea here is to keep the costs down by keeping the litigation down.

Mr. GOODLING. Mr. Chairman, he is not a Moses so I don't know whether he will let his people go, but I yield 3 minutes to the gentleman from South Carolina (Mr. GRAHAM), a very important member of our committee.

Mr. GRAHAM. Mr. Chairman, no, I am certainly by no means Moses. Do my colleagues know what I was before I was in Congress? I was a trial lawyer. I was glad to do what I did for a living. Because when somebody came into my office, I tried to help them where I could, and I would always be honest: you do not have a case. I am sorry. It would be a waste of your money and my time.

But every now and then people would come in like the folks that the gentleman from Iowa (Mr. GANSKE) have displayed on the floor tonight. And if my colleagues think suing a hospital or a doctor is easy, they have never done it. They have got to find an expert that will be willing to say the standard of care was not adhered to. And most people that come into the office do not have enough money to pay the bill, so we have got to go into our own account and advance costs.

The most dramatic form of litigation I have ever been involved in is suing health care professionals because most people in the community want to support their doctors and to give them the best benefit of a doubt, as they should. It is traumatic; it is emotional for the doctor and their family. And it is traumatic for the patient; and it is very, very expensive. But it needs to occur in situations where people are wrongfully treated.

We need to have liability over HMOs' heads. When they make a decision for the plan participant, they need to understand that if they nickel-and-dime folks and they do not treat them fairly, they could wind up in a courtroom.

But having made my living in courtrooms, let me tell my colleagues, we could do better than all the options that we have heard about tonight. To say that legal liability does not affect insurance and the ability to have health care is wrong. Legal liability is something employers look at very hard.

I believe, when it is all said and done, that there are no guys with white hats and black hats in this debate. I support Norwood-Ganske-Dingell, and I will vote for it no matter what happens because I believe the Senate Republican bill does not get us where we need to go as a country.

I am going to ask my colleagues to listen to one thing at the end of this debate. I am not a doctor, and I am not

going to practice medicine because it is not what I know how to do. But I am a lawyer. I can tell my colleagues this: we can create a fair day in court for people in this country, but we have got to look long and hard at how we do it. Because one day, if we do not watch it, we are going to drive people out of the health care business.

If we allow State court lawsuits for companies that do business in more than one State, I believe we will have a legal conversation that goes like this: the corporate lawyer is going to tell the company, You are subject to 50 different legal theories of liability. There are 50 different rules out there. And you are going to have to think long and hard if you want to stay in this business.

To give this back to the State where there is no uniformity is going to drive up cost, and it is going to be very complicated to administer. What I suggest is let us keep the Federal court system as it is but allow full range of lawsuits. If they have a bodily injury, sue for the complete recovery of their damages, but let us make it uniform so people do not lose their health care and have some damage limitations.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I appreciate the comments of my colleague from South Carolina (Mr. GRAHAM).

Mr. Chairman, I am a doctor and not a lawyer. So what did I do? When we were looking at drafting this law to help protect employers, we put in a provision that said, unless the employer makes a discretionary decision, they are not liable.

Most employers, most small business people, most doctors, what do they do? They hire an HMO or they hire a health plan, and they do not get involved in the administration of the plan; and so, under our bill, they are not liable.

And so, do my colleagues know what? Since I am not a lawyer, we asked some experts to make sure that our language truly did protect the employers. We asked the senior attorneys at the Employee Benefits Department and Health Law Department at the law firm of Gardner Carton and Douglas to look at our language, does it really protect employers. And guess what they said. They said that it protects employers if they are not involved in that decision-making.

That is what they said in their legal brief on this. They said the provisions in the Norwood-Dingell bill, section 302(a) that protect plan sponsors would be interpreted under the Supreme Court's well-established ''plain meaning'' analysis. Such an analysis supports the Norwood-Dingell bill that the clear intention to continue to preempt any State law liability suits against employers that do not involve an exercise of discretion by them in making a benefit claim decision resulting in injury or death. Other types of discretionary plan sponsor action would not be affected and would not be subject to State law liability claims.

Interpretations of the Norwood-Dingell bill which characterize it as a broad employer liability provision require one to ignore critical elements of section 302(a) which means under the ''plain meaning'' analysis of the Norwood-Dingell bill that employers will not be liable when the HMO that they contract with makes the decision.

That is the lawyers' opinion.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Chairman, I thank my colleague for yielding me the time.

Mr. Chairman, every so often this body gets an opportunity to decide on an issue that has direct impact on the lives the people we represent. Today is one of those days.

At long last, we have an opportunity, through passage of the bipartisan managed care improvement act, to balance the scales of health care delivery in favor of our constituents. And it is long overdue.

The opponents of justice for health care consumers say that we should not pass the Norwood-Dingell-Ganske bill because it would drive up the cost of health care. But they are not telling the American people the truth. The premiums are going up now, but they have not risen disproportionately in the States that have enacted HMO reform.

The American people understand that we cannot put a price on the right to get justice when an HMO refuses to pay for care that was ordered reasonable by a doctor and the patient suffers harm or dies.

My colleagues, the American people are a lot smarter than the HMO industry; and our colleagues who are against this bill give them credit. They can tell whether a particular piece of legislation is good and whether it is not.

How many good doctors have been fired by HMOs just because they continue to deliver a high standard of health care? Norwood-Dingell-Ganske is the only bill that would change that.

Among the other things in H.R. 2723 that the American people support is the fact that it will ensure that people have direct access to OB-GYN services from the health care professional of their choice. Under the Norwood-Dingell bill, if someone has a chest pain, they can go to an emergency room and be seen immediately; if they have a heart attack, they can be treated and stabilized and not have to be transported for emergency care.

My colleagues, a number of States and the courts have already begun to do away with the exemption from being held accountable that HMOs currently enjoy.

Should not all Americans, not just the ones in California, Georgia, Texas, and now Illinois also enjoy this right?

We are having an opportunity to do right by the American people today. Let us not squander that opportunity. Let us pass a right kind of managed care reform, the only bill that does what the American people have asked us to do. Vote yes on Dingell-Norwood-Ganske and no on all the other substitutes.

Mr. CLAY. Mr. Chairman, I yield 1 minute to the gentleman from New Jersey (Mr. MENENDEZ).

(Mr. MENENDEZ asked and was given permission to revise and extend his remarks.)

Mr. MENENDEZ. Mr. Chairman, I rise in support of the Dingell-Norwood bill because it is the only bipartisan bill that addresses the needs and concerns of some families in my district who need a level playing field in dealing with their managed care plans.

I am hopeful, however, we will have the opportunity to provide the funding offsets we were denied on the floor today. This issue is simply too important to families like the one in my district in which a child was denied post-operative care by their managed care plan and, as a result, suffered severe life-long health complications.

It is these families for whom we should level the playing field. And the Republican leadership should be having breakfast with them, not the fat-cat insurance companies who want to kill the Patients' Bill of Rights.

□ 1915

We can ensure that doctors, not insurance bureaucrats, make medical decisions in the best interests of the patient not the health plan.

This is not about lawyers. It is about empowering patients by giving them the right to hold their plans accountable when they are denied care.

The Dingell-Norwood bill levels the playing field, empowers patients and, as a result, ensures access to quality health care for all Americans.

Mr. GOODLING. Mr. Chairman, in passing I might mention that I think that law firm referenced might represent the AMA. I think I heard that somewhere.

Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Chairman, good HMOs manage care. Bad HMOs manage costs. Good managed care has physicians making those decisions not bean counters. Bad managed care has bureaucratic bean counters making health care decisions to cut costs, and that is the problem we should have fixed first.

The good guys and gals who are out of this debate are our employers. Where are they in this proposal? Were they at the table? No. The manufacturers, the contractors, the restaurateurs, the retailers, NFIB, the Chamber, people who make this country work, employers who pay the bill.

I also find it is interesting, are Medicare recipients covered by this? No. Medicaid? No. Veterans? No. Federal employees? No. We pay for their health

care and are responsible. They are not covered.

We are building a Federal bureaucracy like HCFA for our employers to deal with, the good guys. Our employers are frightened by this proposal, and they should be. They were left out in the cold. They were not adequately protected. This proposal takes a meat axe to an issue that a sharp surgical knife could have fixed. We should have made sure managed care used physicians to manage care, not accountants and bureaucrats to manage costs.

Our employers who pay the bill should have had their concerns resolved. That did not happen. The Dingell-Norwood bill will increase the number of uninsured, and what recourse do those who have no insurance have? Nothing is given to them.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentlewoman from Ohio (Mrs. JONES).

Mrs. JONES of Ohio. Mr. Chairman, I thank the gentleman from Missouri (Mr. CLAY) for yielding me this time.

Mr. Chairman, I am sure tired of hearing the other side say that it is lawyers who are causing this dilemma. There is a doctor seated in here this evening who had to sue to be able to practice medicine in California. And he sued and he won. His name is Dr. Thomas Self. There are a ton of people who keep saying the lawyers are keeping the patients out of the hospital and keeping the doctors out of the hospital. Well, we want to be able to get in doctors' offices and hospitals, but it seems the only way we can do that is to sue them because the HMOs will not let us in the hospital.

Now, my friends, the Selfs, and my friend Miles Zaremski, my law school buddy, submitted an open letter to Congress and I would like to include that in the RECORD.

AN ''OPEN LETTER'' TO THE HONORABLE MEMBERS OF THE UNITED STATES HOUSE OF REPRESENTATIVES REGARDING MANAGED CARE LEGISLATION

(By: Thomas W. Self, MD, FAAP, Linda P. Self, RN, BSN, Miles J. Zaremski, JD, FCLM)

SEPTEMBER 29, 1999.

DEAR HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES: We hope that our remarks that follow will be able to be part of the floor debate that will occur on managed care legislation, scheduled for early next month. While we have endeavored to communicate with several of you, either by letter, phone or by in-person conferences with you or your staffs, we feel our individual, yet collective, wisdom on the underpinnings of this legislation before you is critical and important. Two of us have a unique experience not shared by other health care providers in our country. The other has considerable expertise based on experience and writings on managed care liability, what our courts have done with ERISA preemption, and what is likely to be done in the future by our judicial system. Two final introductory remarks. First, there is so much that needs to be said that brevity in our remarks could not be achieved. Second, while this letter comes from the three of us, we refer to each of us in the third person.

THOMAS W. SELF, MD,
FAAP,
LINDA P. SELF, RN, BSN,
MILES J. ZAREMSKI, JD,
FCLM.

Our plea comes not as Democrats, Republicans or members of other political parties. Our plea comes to you as a physician, nurse and lawyer, representatives of those at the crossroads of medicine, health care and law. Our plea comes to you also as people who are deeply and passionately concerned about the quality and delivery of health care for America's patients, all patients, and the legal and legislative efforts to do the right thing—insure fairness and accountability for patients and by those delivering health care.

To quote a famous line from a motion picture of some years back, the battle cry of patients is, ''We are mad as hell and we are not going to take it anymore!'' Patients and providers alike should not be subject to the grave inequities foisted upon them by what managed care has done to the delivery of health care. Linda and Tom Self are fitting and, perhaps, unfortunately, unique examples of what has to occur before managed care moguls will listen.

As a San Diego doctor trained at Yale and UCLA, who ran afoul of managed care and who was actually fired for spending ''too much time'' with his patients, Dr. Self is unique among health care providers in that he fought back against the medical group that fired him and won a three year ''battle'' that culminated in a three month jury trial. His victory is the first of its kind in the nation, and was profiled by ABC's ''20/20'', on August 6, 1999.

His experience, where managed care profit motives infiltrated and contaminated the professional ethics of his medical group, shows clearly the murky and often brutal influences wielded by HMOs which have only profit, not quality of care, as their goal. In this scenario, patients become ''cost units'' and doctor is pitted against doctor, undermining the very foundation of medicine and throwing to the winds the Hippocratic axiom, ''first of all do no harm''.

With the art and science of medicine controlled by managed care forces, it is not surprising that the number of patient casualties continue to soar. The ability of a clerk with no medical training, in the employ of a payor thousands of miles away, to overrule medical decisions of a trained physician is allowed in no other profession, but is the standard of practice under managed care! Furthermore, this type of employee and also the managed care entity which acts as the puppeteer behind the clerk are completely immune from any legal accountability when their faulty medical decisions cause patient harm. That this situation is allowed to continue is also peculiar only to the medical profession. This is unfair and inequitable.

As an experienced diagnostician with the reputation of being thorough and careful, Dr. Self was criticized under managed care dictates as a physician who ordered too many costly tests and as a ''provider'' who ''still doesn't understand how managed care works.'' Sadly, this situation continues nationwide, as more and more experienced doctors are unjustly censored, dropped from managed care plans or terminated from medical groups anxious to conform to managed care policies, leaving their needy patients feeling confused, frightened and abandoned.

This pillage and waste of medical resources (under the yoke of managed care which destroys the very quality and continuity so necessary for a positive outcome from medical treatment) is running rampant in America. Dr. Self and his wife have put their lives and their careers on the line to combat the wrongs caused by the health care delivery system called managed care. Now, representing, in microcosm, all health care providers, they turn to you as lawmakers, representing all past, present and future patients, to stop the horror and carnage by health plans by voting for the Norwood-Dingell bill, H.R. 2723, and restoring quality, decency and humanity to health care for the American people.

Linda Self, a registered nurse, is, like her husband, a healer. Always active in charitable activities, she returned to nursing full time four years ago to work with her husband when he lost his job. After being away from nursing for many years, she realized that her compassion and love for the art of healing was now even stronger, especially after raising two children, one of whom had a serious illness. Devoted to caring for children with chronic disease and giving support to their families, she was shocked and unprepared for the massive de-emphasis on patient care that had been fostered by health plans. Linda realized that her commitment to people had not changed nor had the needs of such children—what had changed, and changed for the worse, was the indifference to patient suffering held by the managed care system. She realized that in order to care for sick patients and their families in the 90's, there is, and was going to be, a constant controversy with the managed care bureaucracy involving patient referrals, treatment authorizations and, above all, the daily need to appeal treatment decisions lost, delayed or denied by their patients' health plans.

As if also in microcosm to what other private medical practitioners face, this office ''busy work'', in addition to the requirements of providing necessary medical support to sick patients, has created enormous frustrations among health care providers as well as increasing the costs of running a practice. Conversely, reimbursements from health plans have steadily diminished, regardless of the severity of the patient's illness or the increased amount of physician and nursing time expended.

Additionally, in her dual role as nurse and office administrator, Linda works daily to insure that patients receive the appropriate medical care they need and deserve without suffering the indignity and humiliation of having their health plans ignore, delay, or deny health care that is not only medically necessary, but for which the patient has already paid insurance premiums. This endless paper shuffle mandated by managed care with its cost cutting mentality further decreases the amount of time that a nurse can devote to patient care. This Dilemma has driven competent and caring paraprofessionals from the medical field in droves, thereby further weakening the overall quality of medical care needed by patients nationwide. The resulting upswing in poorly trained, undedicated office personnel hired to replace the nursing flight has created a hemorrhage in medical care delivery which, if not stopped, will hasten the demise of American medicine as far as any vestige of quality of care which still remains.

Patients must not be considered commodities to be batered by health plans. Payors must be held fully and judicially accountable wherever their pressures on physicians to curtail tests, delay or deny treatment plans, or by clogging the wheels of medicine with mountains of paperwork cause patient harm. Therefore Linda Self, speaking as a mother, a patient, and a nurse brings her experiences to the House floor and adds her plea to those of Dr. Self and Mr. Zaremski to bring dignity and salvation to the practice of medicine.

Those in the House, listen, as we have done for years, to the voices of the grass roots populace when they cry out for help and relief from a medical system that harms, not

heals. Read, if you will, the numerous e-mails and other written communications from viewers of the ABC ''20/20'' program on Dr. Self and other well wishes after he and his wife's historic jury verdict, which we have included as an attachment to this letter. A sampling of quotations from these communications follows:

As an R.N. I have had similar experiences as Dr. Self concerning HMO's. He is the type of doctor HMO's do not want, since he actually takes enough time for each patient, and does the right thing. A warning to all patients: do not choose an HMO if you have a chronic or rare illness! They will hasten your demise; they are Goliath and you are David. * * * Until patients become better-informed and less passive about their health care, and until doctors start standing up, like Dr. Self, HMO's will continue to run over the patients they are supposed to serve.—Sheryl W. McIntosh

Your August 6 piece on Dr. Self who was fired for ignoring his group's bottom line and putting his patient's needs first was excellent. This is happening more frequently than people realize. Only when people have access to information like you provided—or when they get sick and learn firsthand—do they realize how corporate managed care has affected American lives. I hope you will talk to other medical caregivers and deal with other facets of this complicated problem.—Frances Conn

This might be just the tip of the iceberg. Our health care should not be treated as a commodity, i.e., something to make money on at your or my expense. Neither should it be a political football where the vote goes to the place with the most political donations. * * *''—James A. Eha, M.D.

* * * At first HMOs were VERY good but every single year that passes it gets volumes worse. Now, it is so hard to get a referral, a prescription, a test or an office visit. * * * My husband has to take off work because you have to take the appointment they give you. * * * They make it nearly impossible to get care. They have those drug lists that they are always changing so the doctors are changing your meds all the time making you very sick. They do not allow doctors to do their jobs * * *—Diann Wolf

An identical story happened. . .with my brother who is a family practitioner. . . .He dealt mostly with AIDS patients and the HMO found that to be too costly. He and his fellow practitioners in his office decided to leave the medical practice and regroup mentally to figure what to do. They had spent many months without pay at all due to the methods of saving costs by the HMO. . . . And just so the HMO's could make some money, good doctors are leaving the profession.—Michele Drumond

. . . For the past 11 years I have cared for people in long term care. . . . Just imagine the lack of incentive there is for good care of the elderly or disabled. Many newer meds are not covered as they are not cost effective . . . patient loads rise but staffing does not, rules and regulations of documentation rise, staff does not nor does equitable pay. The diagnosis to dollar mentality is ripping the caring soul and commitment out of medicine. Everyday I ask God to give me both compassion and wisdom in my job, but my soul feels that the battle of excellence in care and cost will always be won by cost. I feel called to this job, and just have to do what I do the best that I can, but NEVER would I want any of my four children involved in direct patient care. The physical, emotional and psychological load is becoming too great!! I strongly believe we will see life expectancy decline.—Barbara Harland, RN

. . .I work for a doctors office. . .I do all referrals, authorizations and surgery precerts for our patients. It has become a nightmare to approve any surgeries without going thru the third degree for patients. They can't begin to realize what we in the ''field'' go thru to get these things approved.—Susie Wallace

'There are men too gentle to live among wolves' to a gentle and courageous man & woman [Tom and Linda Self].—Brian Monahan,

. . .It is a great irony that, after a generation of tremendous growth of our knowledge and our ability to care for patients and diseases in a manner far better than we ever could before, greedy companies are seeking to limit our doing so.—Herbert J. Kauffman, M.D.

. . .I deeply respect what you've accomplished and appreciate the way in which your victory benefits patients and those of us who choose to treat patients according to sound clinical decision-making versus adherence to the masters and dictates of those more concerned with profit than quality patient care. . .—Robert Alexander Simon, PhD.

. . . Seven years ago I was hired as a homecare Social Worker. . . . Then, managed care entered the scene—frequently denying approval for a social-worker's services. Since urgent social worker intervention was often necessary with our patients, there were many times that I was dispatched to the patient's home to provide emergency services . . . only to later receive a ''denial of payment'' from the managed care company . . . [Hospital] required me to find any excuse possible to visit those patients whose insurance would pay, and would cram as many patients as possible every day into my schedule. It was all so very, very wrong. For months this unethical practice tore me apart—and eventually made me very ill. I quit my job. . . . I had been forced to compromise my ethics in order for [Hospital] to maximize their profits. I applaud your courage, and I just wanted you to know that I am proud to be the parent of one of your patients.—Ruth Bronske

You stood tall for yourself and set a perfect example for the rest of us. I am so pleased.—George Jackson, M.D.

. . . Congratulations on winning your lawsuit! Truth always comes out triumphant. Hopefully the HMOS . . . of the world will put the patients' interest first and the bottom line at the bottom as it should be from now on . . .—Faith H. Kung, M.D.

. . . Dr. Self stuck his neck out and he lost his job, but he stood up for what he believed in and hopefully other doctors will do the same. He should be commended for what he did. I hope . . . that if something really bad ever happens to me and I need tests run or extensive surgery done, the doctor better not look at what kind of insurance I have rather than giving me the best medical attention I need that could save my life . . .—Kim Lewis

. . . I have quit the medical field in the past month because medicine is no longer about patient care and needs. It is only about how much money can be made off of them. Thank you for letting me see it is not just the employee that is affected!—Linda Copp

As a legislator, you can therefore appreciate first hand, the anger, frustration, and hopelessness expressed by your constituents such as what we have quoted above. Then, recall the quote by Margaret Mead, ''Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has.'' The ''rank and file'', the grass roots populace is, we think, what Ms. Mead had in mind when it comes to health care in our country.

The third major thrust of our letter pertains to the three of us having seen and heard the disingenuous expressions of opponents of what patients really need and which is embodied in the Norwood-Dingell bill. First, we have heard that lifting the ERISA preemption will cause employers to terminate health plans for their employees, that lifting this so-called shield will cause premiums to increase and that trial lawyers will gain an avenue to sue. To all of this, and with all the passion we can muster, we say, ''absolutely not!''

First, ERISA, enacted in 1974, had nothing to do with shielding managed care plans from accountability for their medical decision-making process. There has never been anything in the legislative history on ERISA having to do with this subject. The American Bar Association, not known at all for representing trial attorneys, voted last February 302–36 to lift the ERISA shield.

Next, allowing for accountability by health plans to patients, as contained in HR 2723, provides for real equity in distributing responsibility to all those persons and entities involved in the medical decision-making process. This does *not* mean increased or additional litigation! The liability exposure to managed care entities that would exist with removal of the ERISA preemption shield will force these entities to insure improvement in patient care, by, for example, not allowing clerks to override physician treatment decisions, providing a review process to all treatment denial determinations, etc. As a result, the number of bad-outcomes leading to litigation will likely decrease, leading to less litigation. And where bad-outcomes do occur, allowing direct suits against health plans will not create more lawsuits, but will rather lead to roughly the same number of lawsuits—with one additional defendant. this one additional defendant will better allow a trier of fact to equitably distribute liability to the persons and entities responsible for the harm. In the end, there are fewer bad-outcomes, less litigation and better equity in the distribution of fault.

Also, realize that HR 2723 provides for accountability and responsibility of health plans according to state laws. State courts are where this area of responsibility and accountability for health plans should reside. For example, if your state has ''caps'' on the amount of money that an injured person could receive, such as in California, then those caps would equally apply to exposures faced by health plans.

And if the Texas state statute on holding HMOs responsible is any example, fears of increased litigation are totally without any basis in fact. In the three years since that state's law was enacted, there have been less than a handful of cases filed against health plans in that state. Also, in joining with Georgia legislators, the California[1] state assembly of 80 members (overwhelmingly) passed legislation recently providing that HMOs can be held accountable for their medical decision-making. On September 27, 1999, Governor Grey Davis signed into law this legislation, and, in so doing, stated, ''It's time to make the health of the patient the bottom line in California HMOs.''

In conclusion, we implore each and every one of you to do the right thing. Vote your conscience by voting for the rights of each and every American who has been, or will be, a patient in our health care delivery system. Remember that a person's health is *unlike anything* that can be bought, traded, negotiated or sold. Don't hold hostage human sickness and injury to a ''bottom line'' mentality. Keep in mind the words of a colleague in medicine who wrote Dr. Self after his jury verdict, ''The rewards of being a doctor are largely measured in indentifying what is

[1] California is said to be the ''birthplace'' of managed care.

best for the patient and then having to do what one believes is correct and best for the patient.'' Again, we reiterate the quotation by Mead: ''Never doubt that a small group of dedicated people can change the world. Indeed, it is the only thing that ever has.'' In passing HR 2723, each one of you will heed her message, and, accordingly, insure that the tendrils of greed and disregard for legal accountability in managed care will no longer be able to find fertile soil in which to take root and grow.

Thank you.

Sincerely,

THOMAS W. SELF, MD, FAAP,
LINDA P. SELF, RN, BSN,
MILES J. ZAREMSKI, JD, FCLM.

They say that Norwood-Dingell will restore medicine to physicians not bureaucrats. They say that it will provide for medicine over money and not the bottom line. They say that it will provide for patient care over profits. They say that it will provide judicial accountability for all entities involved in the medical decision, and I agree with them.

Dr. Self said to me, remember that a person's health is unlike anything that can be bought, traded, negotiated, or sold. He said, do not hold hostage human sickness and injury to a bottom line mentality.

Mr. Chairman, I strongly support H.R. 2723, and we will ensure that greed and disregard for legal accountability and managed care will no longer find fertile soil in which to take root. Support H.R. 2723.

Mr. CLAY. Mr. Chairman, I yield 5 minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I thank the gentleman from Missouri (Mr. CLAY) for yielding me this time.

Mr. Chairman, in this debate we have come a long way. We are actually beginning to agree on some things. I am proud of my good friend, the gentleman from Ohio (Mr. BOEHNER), for having an external review provision in his bill. In fact, we all do, because all of us understand that is precisely the better way to get our patients the care that they need.

I would like to speak to the gentleman from Pennsylvania (Mr. PETERSON) before he leaves. I noticed that he made a couple of remarks about employers, that they are not involved.

I will say, I have been doing this a long time, 5 years, and I do not know many employers I have not met with. I am sure there are not many I have not begged to come to my office over the last 5 years, from General Motors, to Wal-Mart, to IBM, to Caterpillar, to you name it.

I have asked them to come. I have said, look, guys, we have a serious problem going on out here. Help me with this bill. I am not after them. I am simply trying to get people to quit practicing medicine that are not licensed.

They did not want anything to do with it. They did not help. They absolutely did everything that they could do to make sure we do not want anything to happen; we like it like it is; we are in control, and that is what we want.

They did not work with us at all, but I worked with them. I worked with them for 3 years, hard. We met with one of them every day. Here is the bill, help us with it. They would not.

Many employers, and I am sure not all, but many employers have had the opportunity to help us make it better and what they want is absolutely nothing.

Now, why? Well, there are two types of employers. Seventy-five percent, I would say, of the 160 million Americans, are in insurance plans that are partially funded and partially administered, and those employers typically they do not practice medicine. They really do not. That is why we have worked very hard in this bill to make certain those people would not be made liable, because they are not sitting there every day, the CEO, trying to tell the administrator, no, this patient cannot have that surgery but this patient can.

The problem is that other 40 million Americans that are under plans, very good plans, too, the big guys, really good stuff, they do practice medicine, though. The gentleman said they did not, but they do. Just because they make tires does not mean they do not have an insurance company in the backyard. I can guarantee they do, and they make decisions of medical necessity, long distance, untrained people, planned and paid to deny care. That is what they do for a living. These medical directors make big money. They do not last long if they do not deny care.

My problem with that is that they are looking at a computer screen. They are not using the art of medicine, the science of medicine. They are going down a mathematical screen on a computer. People are going to be killed like that. Medicine cannot be practiced that way if the patient is at least not looked at.

They never talk to the patient. They just call up and say, no, my computer screen says no. How could that cardiologist possibly know anything, that has been seeing someone as a patient for 30 years, that is a next door neighbor that a lot is known about?

That is the problem; it is that group.

Do I want them out of this? Yes, because basically they do try to do a good job, and basically have very good plans, but there is not a way to take them out of it because they are practicing medicine without a license; and that, Mr. Chairman, is what the problem is.

If we had it all to do again and go back 5 years ago, what would I do? I would make it a Federal crime to practice medicine without a license. That would stop this mess, because that is indeed what is going on.

Now, why are the employers scared? And they are. I am in sympathy with them about that. They are scared because the insurance industry scares them. They have great practice at this, Mr. Chairman. They have been doing it in States across America for the last 20 years. They go in and scare the bejeezus out of these employers. They say, gosh, if this is not done, if that bill is not killed, costs are going up 25 percent. Guys, if this is not done, we are going to find that everybody gets sued every day.

We do not say that in that bill. My word of mercy, I am for employers, too. We have to support, Mr. Chairman, to change the system, a bipartisan bill. That is the only way that I know to get a law in a split Congress with a Democratic president, but it is so important we have to get it done now. This window of opportunity, where we have my friend the gentleman from Ohio (Mr. BOEHNER); my friend the gentleman from Oklahoma (Mr. COBURN); my friend the gentleman from Iowa (Mr. GANSKE); my friend the gentleman from Michigan (Mr. DINGELL); my friend the gentleman from Arizona (Mr. SHADEGG); we are all pretty close to agreement because we all have recognized the fallacy in a system of practicing long distance medicine by people who make their living by denying those claims.

Mr. GOODLING. Mr. Chairman, I yield 5 minutes to the gentleman from Kentucky (Mr. FLETCHER), a member of our committee.

Mr. FLETCHER. Mr. Chairman, I thank the gentleman from Pennsylvania (Mr. GOODLING) for yielding me this time.

Mr. Chairman, I appreciate the opportunity to come and speak. It has not been too long ago since I was sitting face-to-face with patients, practicing family practice, primary care.

We also had a program in Kentucky where we cared for those without insurance. We provided that treatment free of charge. And we saw a lot of folks that would like to have insurance. But they were not able to afford it, or the small business that they worked for could not afford it.

We also solved problems with HMOs, and I have the utmost respect for my colleagues, the gentleman from Georgia (Mr. NORWOOD), the gentleman from Iowa (Mr. GANSKE), and the other folks that certainly have addressed this issue long before I arrived here.

I have had the privilege of working in health care in the State of Kentucky, and I do know that projections of increase in costs and those sorts of things are tenuous. The real fact is we do not know how much any of this is going to cost.

I think there was an article yesterday, an editorial in The Washington Post, that advised us to be careful, to go incrementally, to take very careful steps because, in fact, we do not know how much this is going to increase costs and how many more people this is going to leave without insurance and without health care.

We have 44 million people, increasing almost by a million people a year, that are uninsured and have no health care. And we do not need to take health care dollars and run them into another system. We need to make sure they are running in to providing care for patients that really need it. That is why I came here, and I trust that is why all of us came here.

Since I have arrived here, I found one thing out, Mr. Chairman. There are some very loud voices here. I have heard the loud voices of trial lawyers, or people that take that position, providers, employers, insurance companies. Sometimes those voices get so loud that we cannot hear the patients back home. We cannot see the number of folks that are getting the kind of health care that they need because their employer voluntarily provides that.

I have companies like Toyota and 3M, Caterpillar, Johnson Controls, Trane, Cooper Tires, and I could go on and on, Dana, et cetera, et cetera, that offer the kind of health care, and I visited those plants and I have gone through, and I have asked the employees about this. They have some of the best health care in this country. I do not want to threaten that, but we do need to do something to make sure that physicians make decisions not insurance companies.

I think we have done that with many of the bills. We have said, let us make sure we have internal review. And I am glad that we want to make sure it is a physician in many of the bills, but we also say there is an independent panel that can look and decide, a panel of experts decide what is medically necessary and what is needed. And then the decision lies with physicians not insurance companies. I think that is important.

We need to look at the other provisions of the bill. Certainly we want to make sure they have access to emergency room, they have access to the OBGYN and their pediatricians, that they can go to the emergency room so we do not see the kind of problems the gentleman from Iowa (Mr. GANSKE) has brought out about a patient that wanted to go to the emergency room and had to go to a distant one. Our bill takes care of that.

I am very concerned about the Norwood-Dingell bill, because I am concerned about where would some of the money go of increased costs. I want to hold insurance companies accountable, but to open up unfettered liability is something that I have felt like has increased costs. And I think many other folks have documented the increased costs over the years, and I do not think there is any question that it will increase cost and more money will go into the pockets of trial lawyers instead of providing care for patients.

According to the General Accounting Office, it takes an average of 25 months, more than 2 years, to resolve a malpractice suit. At the same time, patients typically receive only 43 cents on the dollar.

□ 1930

Defensive medicine, Mr. Chairman, is the practice of ordering tests, and the American Medical Association has said that about 8 out of 10 doctors practice defensive medicine because of the fear of trial lawyers. One study touted by the AMA, was in 1996, reported by Daniel P. Kessler and Mark McClellen of Stanford University, published in the Quarterly Journal of Economics.

This study found that tort reforms directly limiting the liability of medical care providers could reduce hospital expenditures by 5 to 9 percent within 3 to 5 years of adoption basically by eliminating unnecessary testing associated with defensive medicine.

I want to make sure that physicians make the decision, but I do not want us to put money in trial lawyers or to have the practice increase of defensive medicine. I think it is important, and we have got one estimate of Stanford researchers that extrapolating the savings to the national level of researchers, if we had some tort reform, unlike what is in the Norwood-Dingell bill, would save an estimated $50 billion per year.

I think we need to be very careful as we are doing this. As my colleagues know, we can always come back a year, 2 years, or whatever and improve what we are doing; but I think this leap to the Norwood-Dingell bill, a leap that will increase the costs, decrease the availability of health care, and I discourage or I encourage my colleagues to vote against the bill.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Chairman, I rise today in support of the Dingell-Norwood bill, in support of this bipartisan managed care reform legislation, a bill that puts patients ahead of politics and allows us an opportunity to address American's concerns regarding health maintenance organizations. This bill provides important patient protections such as ensuring that medical judgments are made by medical experts, not insurance bureaucrats, ensuring that individuals have access to emergency medical services, clinical trials, prescription drugs.

In addition, this bill ensures that individuals have a right to see a specialist, access to out-of-the-network providers, and holds HMO plans accountable when their decisions to withhold or limit care injures the patient.

We have an opportunity today to listen to the over 80 percent of the individuals in health plans who have cried out for reform of HMOs. We have an opportunity today to make sure that women do not have to see a gatekeeper before seeing their OB/GYN specialist. We have an opportunity to improve the quality of health care individuals receive.

In my congressional district we have 22 hospitals, three VA medical facilities, countless community health centers, half a dozen HMOs all providing quality health services throughout Illinois. This bill will facilitate opportunities for doctors and patients to form a strong relationship and make important decisions regarding their health treatment.

Let us take a historic step forward. Let us vote in favor of Dingell-Norwood. A vote for Dingell-Norwood is a vote for real reform of managed care.

Mr. CLAY. Mr. Chairman, I yield 3 minutes to the gentleman from New York (Mr. NADLER).

Mr. NADLER. Mr. Chairman, I rise in support of the Norwood-Dingell bill and in opposition to the three substitutes that will be offered. This legislation will restore medical decisions to where they belong, to patients and their doctors.

Mr. Chairman, quality health care should be the right of every American, but this principle seems to have been lost in recent years as more and more people have been forced into a managed care system in which HMOs are involved in a zero-sum gain. Every dollar not spent on health care is another dollar of profit for the HMO. Every incentive in the system is not to allow the specialist referral, not to allow the diagnostic tests, not to allow the treatment. The HMO has every incentive to overrule the doctor's judgment or to exert financial pressure on the exercise of that judgment, and they do so every day.

Mr. Chairman, this destroys the confidence a patient should be able to have in his or her doctor's judgment and often causes unfavorable medical outcomes, avoidable deaths and suffering. The American people are crying out for reform, and this bill provides it.

One of the most important provisions of this bill will prohibit an HMO from providing a financial incentive to doctors to limit treatment for their patients. It is wrong to put doctors into a conflict of interest situation between their medical judgment on the one hand and their pocketbooks on the other.

I introduced a bill to prohibit this practice in 1993, and I am pleased that it has been incorporated into this bill.

We have seen a lot of negative publicity surrounding this bill. The insurance industry has waged a campaign of misinformation. They claim this bill would open up a flood of lawsuits against employers, but anyone who takes the time to actually read the legislation will find that it is a balanced bill that protects the interests of employers, doctors, and patients.

The greatest distortion concerns the liability provision. This provision says that whoever is directly responsible for making a decision that harms a patient must be held accountable for his or her action. If an HMO practices medicine, if it does so negligently, and withholds necessary medical care and the patient is hurt by this, the HMO should be liable to a malpractice lawsuit.

This is a matter of simple justice. It is also the only effective way to deter withholding necessary medical care in order to save money.

Every other person or corporation in this country is held responsible for the consequences of their actions, responsible at law if necessary. Why should HMOs be the only entities in this country not held responsible for the consequences of their actions at law?

Contrary to what the insurance companies would have us believe, this bill would not open employers to liability if their involvement was simply to contract with a negligent HMO, nor would an employer who advocates on behalf of his or her employees be held responsible. This bill would eliminate the common HMO gag rules so that information can flow freely between doctors and their patients.

It would ensure full access to clinical trials, greater choice of doctors and plans, continuity of care, access to services for women and access to emergency care and specialists, and it would hold insurance companies accountable for their decisions. It would go a long way toward ensuring that people have access to the treatment they need. We must not settle for less.

Mr. GOODLING. Mr. Chairman I yield 4 minutes to the gentleman from Arizona (Mr. SHADEGG).

(Mr. SHADEGG asked and was given permission to revise and extend his remarks.)

Mr. SHADEGG. Mr. Chairman, I thank the gentleman for yielding this time to me, and I want to begin by pointing out the bill. Would the gentleman bring me a copy of the bill? I want to point out that in this debate there is a lot of misinformation. One piece of misinformation that is going around is that this legislation does not protect existing lawsuits authorized by State law.

Here is a copy of the Norwood, excuse me, of the Coburn-Shadegg substitute. If we turn to Page 91, any Member can read the language; and it plainly says for Texas, for Georgia, for Louisiana, every State action has been preserved; and it says that not only are State actions already created at State law by State legislative conduct, preserved, but those authorized by future legislation are preserved as well.

Now let us turn to some of the debate that I think goes to the issue of Norwood-Dingell.

I respect my friend, the gentleman from Georgia (Mr. NORWOOD). I know his intentions are good in this debate. I believe that he has done a great service by forcing this debate to occur here tonight.

But the reality is there are two extreme positions in this debate which is going forward on the floor tonight and will continue tomorrow. Those two extreme positions are represented by the HMOs on the one side who say we must continue to have absolute immunity. On that issue I could not agree more with my friend, the gentleman from Georgia (Mr. NORWOOD), or my friend, the gentleman from Iowa (Mr. GANSKE).

A good friend of mine in Arizona said the other day why would we want people who have to get a license to practice medicine to be held liable, but people who do not have to get a license to practice medicine, not to be held liable? So on that issue, on the concept of liability I agree that we must change the system. But if immunity is one extreme, we cannot ever be held liable when we kill Mrs. Corcoran's baby.

Mr. Chairman, I have to point out that absolute liability is the other extreme; and my friends on the opposite side, from the Democrat side, my friend, the gentleman from Georgia (Mr. NORWOOD), when he joined with them embraced the other extreme in this debate, and that is absolute liability, and let us talk about one example of that.

In their enthusiasm to deal with this, they swept into their legislation fee-for-service plans. I will tell my colleagues fee-for-service plans regulated at the State level should not be brought into your legislation, but they are. They are already regulated at the State level. The State insurance commissioners cannot handle them, and they can already be sued. But my colleagues sweep them into their regulatory net. That is going too far.

Let us talk about lawsuits that can be brought without exhausting the administrative review. My colleagues' bill says the minute somebody becomes dissatisfied with the plan, they can file a lawsuit. It is like simply having to allege that a marriage is irreconcilably broken. All one has to do is decide they want out, decide they want to go to court and they are in court. Well, that is no system. We ought to force patients to at least ask the plan to do the right thing. But my colleagues allow them to sue without any exhaustion of administrative remedies. They just open the door at any time.

Let us go beyond that. Lawsuits over anything.

Our bill says the Coburn-Shadegg substitute says we allow suits over covered benefits. If they cover this benefit, then they got to provide the benefit, and if they do not provide the benefit, we will allow an appeal; and we will probably allow a lawsuit. But my colleagues allow a lawsuit over anything, not just covered benefits; and what that means is that a panel of doctors or a court can come in after the fact and say, you may not have thought you covered this, but we are going to mandate that you should have covered it.

Now think about that from the insurance policies position. They thought they insured this podium, but they have just discovered they insured the table as well, and nobody told them. That is not fair. It is the other extreme of the end of the pendulum.

And what about lawsuits without limits? Nobody, nobody in this system does not understand that if we, and I implore, I implore colleagues to look at the costs that they can drive. If we allow too many lawsuits, we will produce a million more uninsured Americans.

I urge my colleagues to support the Coburn-Shadegg amendment.

Mr. CLAY. Mr. Chairman, I yield 4 minutes to the gentleman from Iowa (Mr. GANSKE) to respond to the gentleman who just spoke.

Mr. GANSKE. Mr. Chairman, let me respond to a couple comments that have been made. I appreciate the comments of my good friend from Kentucky (Mr. FLETCHER). I just wish that he would listen to some of the arguments by the American Academy of Family Physicians that endorses the Norwood-Dingell bill. I would also point out to him a study. He is concerned about costs, costs of litigation? Well, here is a study by Coopers and Lybrand. This study was conducted for the Kaiser Family Foundation. They looked at group health plans where one can sue their HMO. Okay. They researched the litigation experience of Los Angeles School District, California Public Retirement System and the Colorado Employee Benefit System, and what did they show? That the incidence of lawsuits was very low, from 0.3 to 1.4 cases per hundred thousand enrollees per year and that the cost of that was 3 to 13 cents.

Now let me talk about some of the comments that my good friend from Arizona made. I hardly have time. I am glad that now on the fifth or sixth draft of the Coburn-Shadegg bill we are finally going to have an exemption for California and Texas. It has been hard to pin this bill down; it has been changed so many times.

I would also point out, yes, the Coburn-Shadegg bill requires that a patient has to exhaust all available administrative remedies before going to court. That does not make any sense in situations where the patient has already been seriously injured, or even worse, has died.

My colleague is correct. The Norwood-Dingell bill allows patients who have already suffered harm to go to court. How can you justify a provision in yours that says that, Gee, you have to exhaust all of your appeals. They can be dead before that, or they are already injured.

Mr. NORWOOD. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to my friend from Georgia.

Mr. NORWOOD. Mr. Chairman, I would like to ask my friend a question. If that provision were to hold, then would the insurance companies not just simply delay getting them through all these appeals until the patient dies? Then they do not have to pay any benefits.

Mr. GANSKE. Absolutely, and I also point out that the punitive damages relief provision in our bill is applicable to all insurance.

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Mr. Chairman, let us look at the issue of how the Norwood-Dingell bill applies it to everyone. Yes, it applies to fee-for-service plans. Do Members know why? Because that is a benefit to the independent insurance policies.

We have a provision in our bill that the Democrats were kind enough to go along with, a very Republican provision, that says, if a health plan follows the advice of that independent panel, they cannot be held liable for any punitive liability. Think of that. That is tort reform. That applies not just to group health plans, that applies to all health plans.

That means that the Blue Cross-Blue Shield plan in Pennsylvania now will get a total punitive damages liability if they have a dispute and then they follow that independent panel's decision. They do not have that now. That is a very good provision in our bill.

Mr. NORWOOD. If the gentleman will continue to yield, Mr. Chairman, one of the reasons we wanted to make sure that we had good tort reform that would particularly protect the fee-for-service plans is that under State law, which we are pretty fond of, there are only 22 States that cap punitive damages, so we wanted to get them all. We have them all under there. But under State law, there are 24 States that limit non-economic damages.

There is not any Federal tort reform. We have tort reform at the State level. That is where we always have dealt historically with problems in the health care field with medicine, malpractice, and tort, is at the State level. We like it there, because it has these wonderful, absolute limits in there.

Mr. GANSKE. I would remind my good friend, the gentleman from Georgia, is it not Republicans who stand in this aisle who say the States are the laboratory of democracy? Is it not my good friends, the Republicans, who say, hey, we want to get power back to the States? Do Members want to support a bill that eats up States? I do not think so.

Mr. CLAY. Mr. Chairman, I yield 2 minutes to the gentlewoman from California (Ms. LEE).

Ms. LEE. Mr. Chairman, I want to thank my colleague for yielding time to me, and for his commitment to health care for all Americans.

Mr. Chairman, I rise in strong support of H.R. 2723, which will provide protection for patients in managed care plans.

Patients should not have to face obstruction when they seek basic health care, and they should have the right to sue HMOs when careless or questionable decisions are made. Patients should not have to agonize with obtaining proper medical care while they struggle with their health problems. During these periods of life, times should be less stressful, rather than more burdensome.

This bipartisan bill allows patients to appeal their grievances when they are denied basic health care. It is wrong that millions of Americans and their families are still denied these simple rights, and continue to be denied for so long now. It is about time that medical decisions be made by the patient and his or her physician, rather than account executives or insurance bureaucrats.

In my home State of California, our Governor, Governor Davis, just signed legislation to enact historic health care reform within the State. These laws offer similar proposals to H.R. 2723 in allowing dissatisfied patients the right to appeal and seek redress from HMOs.

California patients now have many more protections than the rest of the country. Patients across the Nation, however, should also have these protections. We must not limit access to health insurance, but we should put the health of all Americans before the interests of special interests. Let us vote for H.R. 2723, and put people first when it comes to life or death decisions.

Mr. CLAY. Mr. Chairman, I have no further requests for time, and I yield back the balance of my time.

Mr. GOODLING. Mr. Chairman, I yield myself the balance of my time.

The CHAIRMAN. The gentleman from Pennsylvania (Mr. GOODLING) is recognized for 3 minutes.

Mr. GOODLING. First of all, Mr. Chairman, I want to make sure that if the Norwood-Dingell bill is a tort reform bill, I sure hope the leadership does not ask them to write some major tort reform bill. We are in trouble if that happens.

Let me close by first of all indicating what the Washington Post said recently. I quote: ''Those who favor regulating the industry do so in the name of preserving access to care for those it insures. But to regulate in such a way as to weaken cost containment and price more people out of the market would likewise have the effect of reducing access, just for different folks.''

They continue, ''The need is for greater balance than an increasingly partisan debate such as this may allow. You should legitimatize managed care by keeping it within acceptable bounds without crippling it.''

They close by saying, ''Our first instinct would be to try an appeals system first, and broaden access to the courts only if the appeals process turned out, after a number of years, not to work.'' So I repeat the call I made to my committee so many times, and now make it to the entire Congress.

When the final bell rings, after the conference is concluded with the Senate, if we have not insured the 44 million who are uninsured, we have done a great disservice not only to those 44 million, but to all Americans who are now picking up the burden in the cost-sharing process that goes on. If we have not, at the end of this day or the end of that conference, made sure that we did not uninsure, no matter how unintentional it may have been, uninsure those who are presently insured, then, again, we have done a great disservice. If one person becomes uninsured because of any action that we take here in the House or in conference, again, we have done a great disservice to the American people.

It is my hope that by the end of the time when the conference is over, that, as a matter of fact, we have tackled the number one health care issue in this country, and that is, insuring the uninsured. All should have that opportunity to be insured, and at the same time, making very sure that we do not uninsure by destroying a system that has worked so well that provides health care insurance for 125-plus million people in this country.

Thanks to the Employee Retirement Income Security Act, that has worked. So my hope would be that we build the whole program on the Boehner-Goodling program, so that we do not make a mistake and destroy what it is we are trying to do; build incrementally, starting with Boehner-Goodling.

The CHAIRMAN. All time has expired for the Committee on Education and the Workforce.

Pursuant to the rule, the gentleman from California (Mr. THOMAS) and the gentleman from Maryland (Mr. CARDIN) each will control 30 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Chairman, I would ask the gentleman from Maryland to proceed.

Mr. CARDIN. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I have been listening to my colleagues debate this issue for the last 2 hours. I marvel more about the fine work that the gentleman from Georgia (Mr. NORWOOD), the gentleman from Michigan (Mr. DINGELL), the gentleman from Iowa (Mr. GANSKE), and the gentleman from Arkansas (Mr. BERRY) have done. They have given us a bipartisan bill, a consensus bill, that will move forward on the Patients' Bill of Rights. It is a good bill. It will make a lot of progress in areas that we need to do.

The first question is, why do we need to pass Federal legislation in this area? There is a very simple explanation. It is called Employee Retirement Income Security Act. We at the Federal level have prevented our States from effectively providing protection to many people in our own State. We have preempted the States, and yet we provide no protection at the Federal level for many of our people who are insured under Employee Retirement Income Security Act plans. Therefore, we need to enact Federal legislation.

The concerns out there are great. We know that in too many cases, medical decisions are being made by insurance company bureaucrats, not health care professionals. We know that HMOs are putting roadblocks in the way of our constituents needing necessary medical services by requiring them to go

across town to see a primary care doctor before they can see a specialist, over and over and over again.

The Norwood-Dingell bill is a reasonable bill that establishes national standards to protect our constituents. Let me just mention a few of the provisions I am particularly pleased with, that I have worked on for many years with many of my colleagues in this body.

There is access to emergency care. We have been working on this bill for many years. I thank my friend, the gentleman from California, for the work that he did in expanding these protections to our Federal health care plans, including Medicare and Medicaid.

Many States have already enacted access to emergency care, as my own State of Maryland has. But the Maryland law does not apply to over half the people in Maryland because of the preemption under Employee Retirement Income Security Act.

Access to emergency care will say that if your symptoms dictate that you need emergency care, the HMO must pay for that emergency care. That is reasonable. Too many times a day HMOs are denying payments of emergency needs because the final diagnosis was not life-threatening. Sometimes we think that they want you to die before they are willing to acknowledge that there is an emergency.

Then there is the independent appeal that I have been working on with many of my colleagues for many years to guarantee that if you disagree with your HMO, you have the ability to have a review of that decision by individuals that do not have a financial stake in the outcome of that review. That is only fair. We have that, again, in many of our States, we have that in our Federal health care plans, but it is not there for Employee Retirement Income Security Act plans, because we have preempted the States' ability to act.

The use of clinical trials. In many cases it is the best health care available for our constituents. The gentlewoman from Connecticut who was on the floor has been very instrumental in moving forward with the clinical trials issues. This bill will provide basic protection to our constituents to be able to participate in clinical trials.

There are many, many other provisions in the bill that go to eliminating the gag provisions, the availability of specialists. Let me deal with some of the issues that the opponents have raised, because I do think they are without merit, and the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) have both done an excellent job in explaining that.

As far as compliance, the Employee Retirement Income Security Act shields the HMOs from liability. We cannot bring cases against them today for the consequences of their negligent acts. We all agree that that is wrong, so the Norwood-Dingell bill says, okay, let us do it this way.

First, we are not going to hold employers liable unless they are directly involved in the management of the plan. Secondly, in regard to the insurance company, if they follow their appeals process, we protect them from punitive damages. That seems like a reasonable compromise on compliance.

Let me deal with the issue of cost. We have heard over and over again, this is going to increase costs. Mr. Chairman, we have these reforms in place, including the compliance provisions, in many States in the Nation. We have not seen any dramatic escalation of costs. Many of these reforms are already in our Federal health care plans, and we have not seen an escalation of costs. I think good health care will reduce costs, not increase costs.

Mr. Chairman, we have heard it is going to be tough for a multi-State company to comply with laws in different States. Mr. Chairman, historically insurance has been subject to State regulation. That is what we thought was best. A multi-State company has to comply with the different State laws on workers' comp and unemployment compensation. This is not a burden for them to understand how the local court systems work. After all, they are located in these States.

It is for all these reasons and many more that over 300 groups, including health care professionals, consumer groups, the League of Women Voters, urge us to pass the Norwood-Dingell bill, and I urge my colleagues to do that.

Mr. Chairman, I reserve the balance of my time.

Mr. THOMAS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am sure that by now people trying to follow this debate are thoroughly confused. When we look at the plans, there are significant portions of the various bills that are identical. The reason for that is that in 1997, when we worked together to produce the most significant change in the Medicare system since the beginning of Medicare, the gentleman from Maryland (Mr. CARDIN) and others joined together with me to produce a bill which we thought was responsible in the area of emergency rooms, gag rules, and most of what is in, in a specified fashion, all through the bills.

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Obviously that is not what is at issue tonight and tomorrow. It is the question of who can sue whom, when and how.

If my colleagues look at that and examine the various bills in that regard, what we hear over and over again in an attempt to defend Norwood-Dingell and its reasonableness or appropriateness dealing with employers is ''unless,'' ''if,'' ''and,'' ''but.'' What we have is hedging. Because, frankly, at the end of the day, employers, through no fault of their own, can be liable under Norwood-Dingell.

When employers are faced with potential liability on something which is an option to begin with, which has continued to increase in cost to the employer, there will be some employers who say I have had enough.

In contrast to that, if my colleagues will look at the Goss-Coburn-Shadegg-Greenwood-Thomas substitute, we can say this: employers cannot be held liable if they provide health care coverage, in selecting a plan, in selecting a third-party administrator, in determining coverage or increasing or reducing coverage, intervening on behalf of an employee, or declining to intervene on behalf of an employee.

When we look at what is available in terms of remedies, one of the things that concerns people is the open-endedness of the ability to sue. When we compare, for example, the Norwood-Dingell bill, it basically says that someone has a right to sue for something that is denied to them under a health plan. One also has the right to sue for something that is not under the health plan.

Now, how in the world, when it is entirely possible that a benefit request that is requested for external review does not have to be under contract, and a court can grant a benefit that is not under contract, that creates an open-ended opportunity.

In contrast, the position that the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Arizona (Mr. SHADEGG) have been willing to modify with the gentleman from Florida (Mr. GOSS), the gentleman from Pennsylvania (Mr. GREENWOOD), and myself says that what is adjudicated is in the contract. More importantly, if the plan follows the contract, internal review, and external review, the plan is not liable.

That cannot be said about the Norwood-Dingell plan. If, in fact, there is an ability to bring a charge, no matter how remote, no matter how qualified, it is not the number of cases that are critical. It is the case that says it is not under the plan, and one followed all the rules, but one can still be sued.

No matter how qualified that position is, it is absolutely true that, under the Norwood-Dingell plan, no matter how remote, that can occur.

When an employer looks at that potential exposed liability, there will be, and if one does it, that is too many, a number of employers who will say that exposure, no matter how limited, is too much. That is one of the real key differences that we should be discussing, how much exposure, how much protection, how many safeguards are reasonable and appropriate.

On that ground, I think my colleagues will find that Norwood-Dingell is too open ended, too exposed, too much relying on third parties able to impose themselves and make decisions that are different than were contained between the two parties who originally

wrote the contract. That contract in opposition to the coalition bill is, I think, protected on a far, far higher level.

The gentleman from Georgia (Mr. NORWOOD) has been standing in the well; and if the gentleman from Maryland (Mr. CARDIN) wishes to yield him time, I would be more than willing to respond to him.

Mr. Chairman, I reserve the balance of my time.

Mr. CARDIN. Mr. Chairman, I yield 30 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Chairman, I just simply want to read from our bill about the exercise of discretionary authority. We say very clearly, unlike the gentleman from California (Mr. THOMAS) just described it, we say very clearly in this bill that an employer under any circumstances cannot be held liable for what they want to put in a plan or for what they do not want to put in a plan. That is totally their business, none of mine. They cannot be liable regardless of what happens to anybody. The only way they can be liable is if they deny a benefit, a treatment that is in the plan, and that results in the death of a patient.

Mr. CARDIN. Mr. Chairman, I yield myself 30 seconds to clarify what the gentleman from Georgia (Mr. NORWOOD) was saying.

Not only does the bill specifically provide that there is no cause of action if they do not provide a particular benefit, but what the Norwood-Dingell bill does is say that, if we have a plan of 50 employees in the State of Maryland, that is currently subject to State law, and one that is creative enough to come under ERISA, then we are going to treat both of the plans the same as far as their responsibility is concerned. I think that is a matter of basic fairness.

Mr. Chairman, I yield 3½ minutes to the gentleman from Maryland (Mr. WYNN).

Mr. WYNN. Mr. Chairman, I thank the gentleman from Maryland for yielding me this time.

Mr. Chairman, I rise in support of the Dingell-Norwood bill. It is the truly bipartisan approach that we need to address the issue of HMO reform.

Now, there are several alternatives, and I believe they are well intentioned. I believe, however, Norwood-Dingell is the better bill for several reasons. First, it is bipartisan. It is the only bipartisan alternative which reflects the thinking of both Democrats and Republicans who are serious about reforming our HMO system.

Second, I want to go to the crux of this debate, which has to do with the right to sue. Again, I believe Dingell-Norwood is a superior piece of legislation. Now, if we listen to the opponents of Dingell-Norwood, we would believe that citizens who need health care really want to buy a lawsuit. That is not what people pay their premiums for. They pay their premiums to get quality health care.

The issue of liability, the issue of suits only arises when benefits are denied, care is improper. Under those circumstances, the citizen, the taxpayer, the consumer, the patient gets the best protection under the Dingell-Norwood bill.

Now, some people, opponents of this bill, would have my colleagues believe that this is really just a boon for trial lawyers, and, for some reason, we on the Democrat side in particular, as proponents of the bill, just want to provide welfare for trial lawyers. Nothing could be further from the truth.

Understand this: the value of the right to sue is not in the lawsuit. It is in the deterrence. Because when HMOs understand that they can be sued, they have a strong deterrent to provide best quality, the best quality of health care. That is the ultimate point. The number of suits in relation to the number of patients is ultimately going to be very small.

But the question is, are we motivated by profit or greed, or are we motivated by the fact that, if we do not provide good care, one's patient could possibly sue one.

Now, my colleagues will also hear, well, this will result in a proliferation of lawsuits, and this will overburden the system and increase costs. Not so.

We have an empirical example in Texas which has implemented a program similar to Norwood-Dingell. They have not seen a significant increase in the number of lawsuits. Quite the contrary. Because, keep in mind, lawsuits are time consuming, cumbersome; and, remember, people do not pay premiums for lawsuits. They pay premiums to get quality care.

Now, Dingell-Norwood says one cannot just rush right into court at any rate. First one has to exhaust an administrative process that allows for both internal review within the HMO and independent third-party review by an impartial arbitrator who can look at the situation. In most instances, that will resolve the case one way or the other. At least based on the Texas experience, that is the case.

On the other hand, if one still believes one is aggrieved and the issue is not resolved, one has the opportunity to go into court to get redress for one's grievances.

The bottom line is simply this, we have maximum deterrence to encourage best practices when we have the optimal right to sue. We do not have an experience that tells us that we are actually going to get an explosion of lawsuits. We have, in fact, a system that has very few lawsuits and protection for consumers. Is that not really what we are trying to accomplish?

I believe Dingell-Norwood best accomplishes this goal and best protects the consumer-patient in the purchase of health care services. I urge adoption of Dingell-Norwood bill.

Mr. THOMAS. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, notwithstanding that statement, there is a phrase ''discretionary authority.'' My colleagues can qualify it. They can argue that is what it means. It is not defined.

I guess the most ironic aspect, though, of this discussion is the constant argument that doctors are no longer making decisions, that we have got to put doctors back in the decision-making key positions.

I hope somebody finds that ironic that, in the Norwood-Dingell bill, the question of whether or not someone has been physically harmed is not determined by a medical doctor. It is determined by a jury.

Under the coalition plan, both on the internal review by medical doctors and the external review by medical doctors, that decision is made. In Norwood-Dingell, there is a hole one can drive a medical malpractice case through because one alleges harm and one goes to court. A jury determines something that they have been constantly pleading ought to be in the hands of a doctor.

By the way, was not it desirable for doctors to have medical malpractice? Where is it in the bill? Ironically enough, the argument that they are doing this for doctors does not contain the thing that the doctors have always said they wanted so they would not have to practice defensive medicine, so they would not have to overutilize to protect themselves. Something as simple as medical malpractice, which is present in a number of States, is not available in this bill.

Mr. Chairman, it is my pleasure to yield 7½ minutes to the gentlewoman from Connecticut (Mrs. JOHNSON), a member of the Subcommittee on Health of the Committee on Ways and Means, someone who has worked long and hard on these issues, has examined them, not only from someone who deals with this issue in the Congress of the United States, but who is very familiar with it from her close relationship in the medical community.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I am very pleased that we are having this debate on the floor of the House tonight. I believe that, due to the real intense focus of a group of Members on this issue over the last few months, we have before us three very thoughtful bills.

I do not want the citizens of this country who are watching this debate to miss a very important fact, and that is that any one of these bills would force accountability for health care decisions made by HMOs and able patients to get the care they need.

It is essential that we act during this Congress to pass meaningful patient protections because patients need it, doctors need it, and HMOs need it. For the first time, a national independent external review process will help us identify those plans that routinely deny necessary care.

If we hold them publicly accountable, I guarantee they will change their ways or dramatically lose their patient enrollment. We will also identify those

plans that are providing timely access to quality care and give them the public attention and support they deserve.

Most importantly, a strong external appeals process will reestablish the role of physicians in the health care delivery system as plans must use physicians to review claims internally, and the external review can be made only by physicians with appropriate specialty of training.

So there are many bills before us tonight, but they all have certain core benefits in common. This internal-external appeals process for the first time makes evident nationally controversial decisions made by health plan.

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And that will provide us with the information we need and the power we need to guarantee that patients get the care they need in a timely fashion.

All the bills provide access to OB–GYN care, access to specialists, access to better pediatric care, access to emergency services, continuity of care, access to far better information about benefits, access to clinical trial coverage, and prohibits gag clauses and incentive plans that discourage the delivery of appropriate care. One can hardly say this is a partisan debate when the two parties have come together in agreement on the majority of the issues at hand, and when passage of these positions would address major concerns of the American people and have a substantial impact on the way Americans receive their health care coverage.

Now, there is an additional issue that is controversial and, unfortunately, has turned partisan. Many of us have come to the conclusion that assuring all Americans the right to sue is an important component in increasing health plan accountability. Unfortunately, many of us are also keenly aware that if we create this right to sue in the wrong way that we will create so many opportunities for litigation that the cost of insuring all those possibilities will drive premiums up.

This is an important point, because many Members have said there have not been many suits. Of course there have not been many suits. There is no clear right to sue. But if we look back at physician liability, we can see how suits do drive up costs and how one has to insure to the possibilities not just to the existence. The possibilities of suit contained in the Norwood-Dingell bill will, without fail, increase the number of the uninsured because it will drive premium costs up.

Equally important, if employers perceive themselves as liable, and this is just as big a point, if employers perceive themselves as liable by sponsoring a plan or negotiating benefits, they will drop plans, whether we say they are technically protected or not. So this bill is fraught with dangers, and we must do this job right.

My goal is to place doctors and patients back in the driving seat of health care decisions. Many who have spoken today have worked long and hard to make that kind of reform of the system possible and to assure that patients get the care they need at the earliest stage of their illness. In my opinion, the Dingell-Norwood bill would create systemic incentives to choose lawsuits over timely, independent, external reviews, driving up costs, forcing small employers to drop plans to protect themselves against the possibility of suit, and increasing the number of uninsured Americans.

Without nationwide public review of care decisions, as the external and internal appeals process will provide us, we, as a society, and health insurance, as a product, cannot develop a health care system capable of providing appropriate, timely, and affordable health care. That is why adding the right to sue must be done exactly right and must not be done in a way that creates an explosion of litigation with all the attendant consequences.

I am a cosponsor of the Coburn-Shadegg coalition substitute, because I believe lawsuits are a necessary remedy for patients who have been wronged by their managed care plan's decisions, but I oppose opening up opportunities for lawsuits where none should exist. Let me give my colleagues an example of what I believe to be the systemic incentives to lawsuits contained in the Dingell-Norwood bill.

In laying out the appeals process, internal and external, that bill says the decision must be made within 14 days or as soon as possible, given the medical exigencies of the case. Now, first of all, imagine the Department of Labor writing regulations to define what the medical exigencies are; and imagine the medical community trying to figure out how to comply with those regulations. That is a problem. But the bigger problem is that this passage now creates a case-by-case deadline for the reviewers to meet that can be reevaluated retroactively.

So it is not a 14-day decision. It is a 14-day decision unless it can be done earlier. And that can be a point that can be litigated when we start from the back end of the line and go back and say this process could have made this decision earlier and, therefore, harm has been done and liability is established.

It is that kind of phrase in the Dingell-Norwood bill that gives that legislation, and there are many others I could quote, that create within that legislation a systemic incentive for litigation.

Mr. Chairman, let me close by saying that my goal is to put doctors and patients back in the driving seat of health care decisions. Lawyers driving these decisions is no more desirable in America than insurance companies driving these decisions. The right answer is the 85 percent of these bills that provide greater access to specialists and timely access to appropriate medical care.

On the issue of the right to sue, we must guarantee it protects patients who are harmed by the egregious practices of health plans, and we must provide a clear simple process that avoids the ambiguities that delight trial lawyers, explodes litigations, drives up costs, and drives small employers out of the business of providing health care. The Coburn-Shadegg substitute is the right answer.

Mr. CARDIN. Mr. Chairman, I yield 1½ minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. I wonder if the gentlewoman from Connecticut would return to the mike.

The gentlewoman from Connecticut (Mrs. JOHNSON) is to be commended, because she has really worked hard on a lot of health care issues, but she and I have had a discussion several times on this medical exigencies part. And she has a concern about that.

I think it is necessary to have that in a bill in order that a health plan does not slow walk to the definition. But let me ask the gentlewoman, because I know she feels differently. The gentlewoman would not support a bill that has medical exigency language in it; is that correct?

Mrs. JOHNSON of Connecticut. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. That is correct, I would not support that bill, unless it has a very good appeals process in place.

We were one of the first States to do this, and now the gentleman wants to impose on our appeals process that is working. I do not mind shortening the time. That is not hard for a State to adjust to. But the gentleman wants to impose this language that is very hard to adjust to, and that really throws what is a simple clear system into an unpredictable, and uninsurable liability, I believe, system.

Mr. GANSKE. Reclaiming my time, Mr. Chairman, I want to be clear. The gentlewoman will not support a bill that has medical exigency language in it?

Mrs. JOHNSON of Connecticut. If the gentleman will continue to yield, I will not support the Dingell-Norwood bill because this is one of the passages among many others that create a systemic explosion of litigations.

Mr. GANSKE. Let me point out to the gentlewoman that the bill she is supporting has medical exigency language that she says she does not like, yet she criticizes our bill on, on page 7, on page 11, on page 52, and on page 85. And they all are in the same time frame.

Mrs. JOHNSON of Connecticut. That may be true but it is not in context, if the gentleman will yield.

It is in the context of a totally different ability to sue with all the different definitions. The gentleman talked earlier about the discretion language.

Mr. GANSKE. Here is the language from the bill that the gentlewoman supports. The decision on expedited review must be made according to the medical exigencies of the case. That is in the gentlewoman's bill.

Mrs. JOHNSON of Connecticut. Yes, but in a context that functions very differently than this language does.

Mr. CARDIN. Mr. Chairman, I yield 4 minutes to the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means and a distinguished member of the Subcommittee on Health.

Mr. MCDERMOTT. Mr. Chairman, I thank the gentleman for yielding me this time.

I first want to say that last year, we passed a bill out of this House that was a terrible bill, absolutely terrible bill, and it rightly died over in the Senate. They never did a thing. But the persistence of two Members of this House, the gentleman from Iowa (Mr. GANSKE) and the gentleman from Georgia (Mr. NORWOOD) needs to be acknowledged. They knew what was wrong with that bill, and they came back and persisted and put a bill on the floor which makes great sense to anybody involved in the medical profession. That is why hundreds of organizations, of physicians and other health care providers are deeply supportive of this bill. It is because it meets the needs of people who deal on a day-to-day basis in this field.

There are two issues here that I think are really central. We can get into exigencies and all these fancy words, but there are two things that really this bill is about. One is about the question of ERISA. If we allow that Federal law to protect from this bill a whole series of 100 million people in this country, we will not have done a good job.

The reason we need to preempt ERISA is that we have to give everybody, whether they are under a State plan, in Maryland or Washington State or Nevada or working for a major corporation shielded by ERISA, they all ought to have the same protection. There should be no difference. And that, in my view, is what the number of all these other bills are about, is to keep that ERISA protection some way or other that they will be treated differently.

Now, the second issue, and I think this one is more personal. Having recently been a patient and having had open heart surgery, I have been in a hospital and I had my chest opened and they did all this stuff, and within 5 days the doctor came in and patted me on the back and said, ''Jim, you can go home.'' Now, the essence of why we are here on this patient protection act is that everybody, when they are vulnerable, as I felt then, wants to know that that decision was made by my doctor, who knows me and cares about me. I do not want some insurance company person saying, ''Well, let me see. Open heart surgery: 5 days. Home you go.'' I want it to be my doctor that looks at me and listens to my chest and makes the decision.

Now, the gentleman from California says, oh, this is no problem, doctors making the decisions, blah, blah, blah. Is that the reason we had to come in here and pass a bill prohibiting drive-by baby deliveries, as we did 2 years ago? And the next year we came in and we stuck an amendment into a military appropriations bill or something or other, an authorization, saying that we were not going to have drive-by mastectomies. A woman comes to the hospital in the morning; and in the afternoon, she goes home. Who decided that? Did the doctor decide it? No. Insurance companies were throwing people out in the afternoon. And we said, wait a minute, the doctor ought to have something to say about that.

And this whole issue is about whether or not we give the assurance to all the American public that when they are in a vulnerable state after surgery, after cancer treatment, after whatever, that they have the assurance that it is their provider that made the decision about what happened to them. They do not want to sue. I did not want to sue. I simply wanted the assurance that my doctor made the decision.

Mr. THOMAS. Mr. Chairman, I yield 2 minutes to the gentlewoman from Illinois (Mrs. BIGGERT).

(Mrs. BIGGERT asked and was given permission to revise and extend her remarks.)

Mrs. BIGGERT. Mr. Chairman, I rise in opposition to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act.

Mr. Chairman, I have heard much talk in this chamber about what is wrong in the area of private health insurance. Members from both sides of the aisle have concentrated on what is wrong with HMOs and ignored the many good things that have happened and are happening in private health care.

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What I think we are forgetting is that employers are voluntarily providing health insurance coverage for their employees. What we are also forgetting is that our employee-based system of health care has been the best in the world and most employees are pleased with their care.

Mr. Chairman, I fear that what we are doing today will jeopardize millions of employees who are satisfied with both the cost and protection offered by their plans. Employers throughout my district tell me the risk of liability will drive them out of the health care business. They will simply give their employees a check. Who loses then? Employees.

Without the ability to negotiate the lower rates secured by their employers, employees will be forced to pay rates double or triple for the same coverage.

Mr. Chairman, the challenge we face today is encouraging more employers to offer health insurance, not fewer. We need access and accountability, but reform should preserve our ability to offer more cost-effective quality health care, not less.

I am afraid the bill offered by the gentleman from Georgia (Mr. NORWOOD) and the gentleman from Michigan (Mr. DINGELL) will produce the latter.

I urge my colleagues to oppose H.R. 2723.

Mr. CARDIN. Mr. Chairman, I yield 2 minutes to the gentlewoman from New York (Ms. VELÁZQUEZ).

Ms. VELÁZQUEZ. Mr. Chairman, we are experiencing a health care crisis in our country. Forty-three million Americans are uninsured. Almost 11 million of the insured are children. One in five uninsured adults went without needed health care in the past year. This is unacceptable.

Equally unacceptable are the more than 50 percent of insured Americans who are in HMOs and are denied coverage in emergencies, access to specialists, and recourse if wrongfully denied necessary medical treatment. This bill does something about that.

What matters to Americans is their ability to take care of their families in an emergency. What matters to Americans is that their children will not be turned away from an emergency room because the hospital is not on the family's HMO plan. What matters to Americans is that they will have access to the best treatment by the best doctor when they or their children are sick.

This bill will protect patients. No longer will HMOs deny patients access to specialists and emergency care. No longer will HMOs gag doctors and restrict their freedom to disclose medical treatment options to their patients.

Arguably, the most progressive element of this bill will allow patients to pursue punitive damages in State courts when they have been wrongfully denied necessary treatment by an HMO.

It makes me sick to hear opponents of this bill try to convince the American public that we will pay inflated premiums because of this protection. I have news for them. We do not buy it. We know who will pay the price if we do not demand more accountability in health care. The American public.

I urge everyone here to vote in favor of this bill. By doing so, we will take the first step toward addressing the health care needs of Americans.

Mr. CARDIN. Mr. Chairman, I yield 4 minutes to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Chairman, this really is a historic day for this House. For the first time, Members will have an opportunity to fundamentally change how managed care operates in this Nation.

For far too long, insurance companies have based their treatment decisions not on what is best for their patients but what is best for the companies' stockholders. It is time to put health care providers and patients back into the business of patient care.

We need the Norwood-Dingell bill to ensure that patients have access to emergency care and to specialists. HMOs need to be prohibited from gagging doctors and other providers so that they are prevented from telling their patients of all the treatment options available.

What are the insurance companies afraid of? Are they afraid of their own policies?

Patients also need the right to appeal when they disagree with HMO suggested treatment. The Norwood-Dingell bill grants patients internal and external appeals, a process to ensure that the best possible treatments are made. The bill permits patients or their families who have been injured or die as a result of the HMO's denial of care to sue in State courts.

What is wrong with that? If the insurance companies are confident of their policies, what is wrong with that? This is America.

The Norwood-Dingell bill, however, does not invite frivolous lawsuits. It imposes the number of limitations on lawsuits. These restrictions include those damages only allowable by State law, no punitive damages provided the HMO complied with an external reviewer's decision and no plan would be required to cover services not provided in the contract.

My State of Texas has a patients' bill of rights. This legislation took effect 2 years ago. And while HMOs serve more than 4 million patients in Texas, there have been only five lawsuits resulting from the legislation. That is hardly a flood of lawsuits.

To quote Senator David Sibley, one of my colleagues when I was in the Texas Senate, the bill's Republican sponsor, ''The sky didn't fall'' with its passage.

The number of lawsuits is low because our patients are fully using the external review process, and that is a component of the Norwood-Dingell bill. More than 700 patients have used that external review process in the past 2 years to appeal decisions made by health plans.

Critics of the Norwood-Dingell bill have said it will increase health care costs. Since Texas's bill of rights has been in effect, premiums in our State have been less than the national average, while health care costs rose 3.7 percent nationally in 1998. The Texas health care cost increased only by 1.1 percent. And these are figures done by the Texas Medical Association.

As a former registered, degreed nurse, I strongly understand the relationship between a patient's involvement in his or her treatment and quality health care. We cannot have one without the other.

The Norwood-Dingell bill will create a treatment environment where patients and doctors can work together with insurance companies to produce the best patient care and the best patient outcomes.

I urge all Members to please support this bill. Let us put health care where the patients are.

Mr. THOMAS. Mr. Chairman, I yield myself 3½ minutes.

Mr. Chairman, there was a colloquy just a short time ago on the exigency question. I had said sometime earlier that it was possible to abort the system under Norwood-Dingell and go to jail if they claim that they have been harmed. And it could be denial of medicine for one day, denial of a procedure for one day. That was the point that the gentlewoman from Connecticut was talking about, that although there are numbers stated in the bill, there are ways to short-circuit those numbers and, notwithstanding the internal and external appeal language, go to court.

What was read from the Goss-Coburn-Shadegg provision claiming to be loaded with exigencies is under the section that deals with the emergency 48-hour provision. The 14-day time frame is the ordinary one in which they are required to exhaust the internal and the external. And then based upon the medical exigency, they have a 48-hour capability.

In other words, instead of writing all of the medical conditions that would trigger the 48 hours, they use the phrase ''medical exigency.'' The English word was the same. The location and the usage was entirely different. I will tell my colleagues, that has been the basis for a number of challenges in this debate. Just because a word is there does not mean anything. As most people know, it is the context, the location, and how that word is used.

Let me also point out that although the Clinton administration is pleading for us to move this kind of legislation, and we are talking about in the coalition bill a fast and fixed 14 days in ordinary situations on the internal appeal, 14 days on ordinary situations in the external appeal, and in both situations, depending upon the medical exigencies, 48 hours.

The Clinton administration, with a stroke of a pen, could change the appeals procedure in Medicare. Do my colleagues know what the appeals procedure in Medicare is today? For Part A on a fair hearing, it is 52 days. And if they want to appeal that decision, on average, it is 310 days.

Why are they not making the kinds of changes in Medicare law that they are arguing ought to be imposed on the private sector?

Now, if my colleagues think that is bad, in the Part B appeals provision, currently it is 524 days. It seems to me a fixed 14 days and in serious conditions 48 hours with medical doctors reviewing the appeal, not the rush to judgment, not the claim of harm, not the ability to go to court and let a jury decide whether or not they are harmed, but it seems to me some folks ought to go back and with a stroke of the pen make the changes in Medicare that they are claiming are so necessary to be imposed on the private sector.

Mr. CARDIN. Mr. Chairman, I yield 1 minute to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Chairman, I appreciate the gentleman yielding the time.

Mr. Chairman, I would point out to the gentleman from California (Mr. THOMAS) that on page 7, lines 25 through 35, are not ''in the expedited care,'' they are ''in the ongoing care.'' And I point out that on page 47, the lines that talk in the Thomas bill are not ''in the expedited area,'' they are ''in the ongoing care'' concurrent review sections.

So I am just glad that my colleague has recognized that there are places in the bill.

Mrs. JOHNSON of Connecticut. Mr. Chairman, will the gentleman yield?

Mr. GANSKE. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Chairman, the concurrent care, that is what the word ''concurrent'' means, it is during that 48-hour period.

In the longer 14-day period, that language does not appear. It is appropriate when they have only 48 hours and they look at whether the person can stay in the hospital then it ought to be as quick as possible, and it is the same argument the gentleman gave me about why it is important.

Mr. GANSKE. Mr. Chairman, reclaiming my time, I appreciate the comments of the gentlewoman because it conforms with what we have said in these certain areas. We need to have some flexibility in that.

Mr. CARDIN. Mr. Chairman, I yield 2 minutes to the gentlewoman from Florida (Ms. BROWN).

Ms. BROWN of Florida. Mr. Chairman, today we have a chance to do the right thing for millions of Americans who are currently being served by the HMO by holding health care plans accountable when they deny patients the care that they need.

I just suffered through a very painful experience of the death of a very close relative. It was a difficult experience made even more difficult because of the HMO restrictions we face.

For example, a family member is in the hospital for a week and they have to come out and be placed back in because even though the doctor said that the person needs to stay in the hospital or they have to go to a rehab, they cannot go to the one close to their home; they have to go to one miles away.

We know their health care plan should make sense. It should not cause headaches.

Mr. Chairman, this bill brings dignity back to the health care for the 4 million people in my great State of Florida who use HMOs. We did not pass a health care plan in 1993. That did not mean that the problem went away.

Shame on this Congress if we miss this opportunity to provide genuine protection from harm to the citizens that are counting on our leadership. Do the right thing and vote for the Dingell-Norwood bill.

Mr. THOMAS. Mr. Chairman, it is my pleasure to yield 5½ minutes to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Chairman, I thank the gentleman for yielding me the time.

Mr. Chairman, I rise to speak in support of the Goss-Coburn-Shadegg-Thomas bill. And let me explain why, should that not pass, I intend to vote for the Norwood-Dingell bill. But first I would like to make a few general comments regarding how we got into the problem that we are in today in the United States with managed care.

A health care plan in the early 1960s, a plan that we all grew up and became used to where there was very little interference in the doctor-patient relationship cost a family of four a few hundred dollars a year. But along came developments like MRI scanners, CT scanners, third-generation cephalosporins, new surgical procedures to treat glaucoma diabetic retinopathy, all good things that prolonged life, improved the quality of life, reduced disability but significantly increased costs.

□ 2045

The pressure of the cost burden on our health care system led many health care economists to look at the perversity in our health care system, where the doctor was not responsible for costs, nor the consumer; the patient was responsible for costs. Both parties were really not regarding costs at all.

Now, what should have been done was exploring alternatives that actually introduced a true marketplace in health care, which is along the lines of some of the reforms we are trying to establish, but instead what was established was managed care, HMOs.

I would like to say, in defense of those entities, while it is true that there are problems in HMOs and people are being injured and are dying, the system that they replaced was a system where people were injured and were being killed, and the body of information on this is out there. It is abundant.

Many economists looked at the issue that there were perverse incentives that caused providers to provide excessive care in some areas such as Cesarian sections, there is abundant data to show that there were too many Cesarian sections; and, yes, there were people who had unnecessary complications; and some people, unfortunately actually, died from it.

Now, I believe it is entirely in order for us to try today to address the problems, the perverse problem in the HMO field, where there is an incentive not to provide care.

Now, I would like to point out to my colleagues that I met with officials from the AMA several months ago; and at that time, they said to me that they thought that a health care reform package that had a good internal and external review, without any litigation language, would be sufficient; and that is because their primary interest was quality of care.

I believe the people at AMA, that is their real interest, in preserving the quality of care. Unfortunately, some of the leaders of the underlying Norwood-Dingell-Ganske bill had come to the conclusion at the same time that I was having that discussion with the AMA that our leadership on this side of the aisle was so determined not to pass any type of reform that they went over to the other side of the aisle and agreed to a proposal that introduces a tremendous amount of new litigation.

If someone asked me what is the real solution to the problem that is at hand, it is to open up insurance companies and HMOs to litigation because they are practicing medicine. Today, when I make rounds at the hospital, third party payers can come in and say, ''No, Dr. Weldon. If you want to send a patient home in 2 days, we do not agree; they have to go home now. No, they cannot go home on that antibiotic, they will go home on this antibiotic.'' That is practicing medicine, and I believe they should be held accountable for that, in all the facets which they are practicing medicine.

There should be reasonable caps and limits on punitive damages and on pain and suffering claims. The other side of the aisle refuses to agree to any of that language, and the President of the United States refuses to agree to any of that language.

The bill we are primarily talking about right now, the substitute with the name of the gentleman from California (Mr. THOMAS) on it, tries to institute some reasonable limits on litigation, reasonable limits on litigation that I feel most of the Republican supporters of the Norwood-Dingell bill actually want to see in place; maybe not this language.

My hope is that as we move from the House to a conference committee, that we will finally have a product that places patients first and the doctor/patient relationship first and that does not open up American courts to more and more litigation.

Mr. CARDIN. Mr. Chairman, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANKSE. Mr. Chairman, I would just like to thank my colleague, the gentleman from Florida (Mr. WELDON), for his support for the Norwood-Dingell bill. He is a family physician. He has been on the front lines. The American Academy of Family Physicians has endorsed the bipartisan bill.

Mr. THOMAS. Mr. Chairman, will the gentleman yield?

Mr. GANKSE. I yield to the gentleman from California.

Mr. THOMAS. I believe the gentleman made a misstatement, and he can take it on my time.

Mr. GANKSE. What was my misstatement?

Mr. THOMAS. The gentleman said he was supporting the Goss-Coburn-Shadegg-Greenwood-Thomas bill and that under the rule, if it passes, I want the gentleman to characterize accurately his statement.

Mr. GANKSE. Mr. Chairman, reclaiming my time, I was accurately stating that the gentleman from Florida (Mr. WELDON) said that he would support the Norwood-Dingell bill.

I hope we get to the Norwood-Dingell bill, to be quite frank. I know the gentleman from California (Mr. THOMAS) will try to prevent that.

I would point out that the American Academy of Family Physicians has endorsed the Norwood-Dingell bill. They are on the front line. My colleague from Florida is on the front line. He understands that we need HMO reform.

I do want to specifically, though, thank the gentlewoman from Connecticut for her remarks because this is about much more than just a debate on liability. The liability provisions that are in this bill are almost verbatim the ones that the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Georgia (Mr. NORWOOD) and I wrote at the behest of the Republican chairman of the Committee on Commerce. Quite frankly, we thought it was a very good faith effort and compromise on the part of the Democrats to agree to a punitive damages liability provision that we have in that bill that would protect employers from any punitive damages liability if they followed the recommendation of that independent panel. I thought that represented a good bipartisan compromise, and I very much appreciate my colleagues from the other side, but this bill is about so much more than that.

It is about emergency services, people getting the care they need. It is about specialty care, people getting the care they need. It is about people who have chronic care problems getting the care they need; women getting the care they need; children getting the care they need, having continuity of care so that the gentleman from Oklahoma (Mr. COBURN) can continue to see his patients and the HMOs cannot yank him around. This is about clinical trials. The American Cancer Society endorses our bill because we have clinical trials in it, as well as numerous other patient advocacy groups.

This is about choice of plans. This is about getting health plan information to beneficiaries. This is about allowing appropriate utilization. It is about allowing internal appeals. It is preventing gag rules that prevent people from getting the information they need. It is about prompt payment of claims. It is about paperwork simplification. These are all things that are in the bipartisan Norwood-Dingell bill. This is about so much more than liability. This is about patients finally having some ground rules that their HMOs have to follow.

Mr. THOMAS. Mr. Chairman, I yield 30 seconds to the gentleman from Oklahoma (Mr. COBURN), one of the central participants in this debate.

Mr. COBURN. Mr. Chairman, I would make two notes. Number one, the American Academy of Family Practice

has endorsed our bill as well, the Goss-Coburn-Shadegg-Thomas bill. Number two is, the gentleman from Florida (Mr. WELDON) is an internist, not a family practice physician. Number three is, we do have cancer clinical trials. And, number four is, we in fact have network adequacy which is not in the consensus bill, which is if there is not an adequate network there is not care.

Mr. CARDIN. Mr. Chairman, I yield 30 seconds to the gentleman from Iowa (Mr. GANSKE).

Mr. GANKSE. Mr. Chairman, my apologies to the gentleman from Florida (Mr. WELDON), who is an internist.

I would point out that the American Society of Internal Medicine has endorsed the bipartisan bill, too.

Mr. CARDIN. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I think the choice here is very clear. There have been many groups and many Members working for many years to get an effective patient bill of rights enacted by this Congress. Three hundred groups have endorsed the Norwood-Dingell-Ganske bill. They understand who has been working to make sure we pass a bill that will be effective, that does the right thing. It is very interesting to see the eleventh hour efforts to try to confuse what we should do.

It is very interesting that the Norwood-Dingell bill has been available. People have looked at it. It has been worked on. It has been given the public airing necessary in order to make sure it is drafted properly.

Now, we saw last year those who did not want to see a Patients' Bill of Rights pass but they did, and bringing out a bill without any real effort made to deal with the issues. Now we see this year an eleventh hour effort in order to confuse the people, but the people are not confused. They know where the advocates are. They know where the people are who have been working on this issue, and it is the Norwood-Dingell bill.

Mr. Chairman, how much time do I have remaining?

The CHAIRMAN. The gentleman from Maryland (Mr. CARDIN) has 1¾ minutes remaining.

Mr. CARDIN. Mr. Chairman, I yield the balance of my time to the gentleman from Maryland (Mr. HOYER).

(Mr. Hoyer asked and was given permission to revise and extend his remarks.)

Mr. HOYER. Mr. Chairman, I thank the distinguished gentleman from Maryland (Mr. CARDIN) for yielding me this time.

Mr. Chairman, I rise in very strong support of this piece of legislation. On Monday, I met with a constituent of mine, Sharyl Asbra of Waldorf, Maryland. She went to the hospital in June complaining of severe abdominal pains. After diagnosing her condition, the doctors recommended she have a hysterectomy, but her insurance company denied the procedure. After weeks and weeks and weeks and weeks of pain, only after Dr. Scott Kelso repeatedly called the insurer on Sharyl's behalf did the insurer relent and let Sharyl get the necessary treatment. This was after she had to be off work, could not care for her children, her mother had to do so, and after she experienced a long period of pain.

This bill is about real people who have a real problem. It is about people who need medical care, as determined by their doctors and by themselves. It is about ensuring that they have access to the medical care that they need, and that that decision will be made by doctors who are trained to make those decisions and who have sworn an oath of personal responsibility to those patients to ensure that they get the kind of quality health care that is available in this country if it will be paid for.

I rise in strong support of this bipartisan bill to help Sharyl and millions and millions of others like her in America.

Mr. THOMAS. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, I would tell my friend from Maryland, he cannot have it both ways. When we were debating the rule, there was plea after plea from the other side of the aisle, do not vote for the rule because they would not let us have an eleventh hour amendment to our bill, and yet they say that they have had their bill without making changes.

They cannot have it both ways. Either they pleaded for an eleventh hour amendment, they did not get it and they voted against the rule, or they have a position they have held for some time.

We can read off hundreds of medical associations. They have endorsed the Coburn-Shadegg bill, just as they have endorsed the other. I can say, we fall by the wayside when we reach about 200 endorsements. The reason we do not reach the level of 300, that the gentleman from Maryland cited, is because we do not have the labor unions and the trial lawyers.

The trial lawyers are endorsing their bill. Why? Because their bill will allow trial lawyers, without medical doctors proving harm, to go to the courtroom and have open-ended penalties imposed by juries. Frankly, we do not think those extra 100 endorsements are the kind of endorsements Americans think should be made in today's health care structure.

Our bill makes sure that medical doctors make the decision, and when the plan is wrong, one can sue.

□ 2100

What I find most egregious is the fact that employers struggling to provide health care to their employees if Norwood-Dingell becomes law, will have to examine the exposure to those same trial lawyers and juries and decide if the risk is worth it. It is a sad statement to make, but I believe a factual one; if Norwood-Dingell becomes law, there will be fewer people covered. On the other hand, if the Goss-Coburn-Shadegg-Greenwood-Thomas bill becomes law, we will have an ordered process, internal and external, reviewed by medical doctors, and if the plan is wrong, they have to provide the coverage. If there has been medical harm, they can go to court, and they can, yes, those now famous phrases, sue their HMO, but it is done in an orderly fashion, and guess what? The trial lawyers do not endorse our proposal. Why? Because it is not open ended, and it is not left up to a jury to determine injury. If we are going to advance medical coverage in this country, it is clear one of the things we have to do is to allow patients to get what they rightfully deserve, and, if harmed, to get proper adjudication. But what we do not need is open-ended trial juries with trial lawyers endorsing the process. They proudly announce they have the trial lawyers on their side. We proudly announce we do not, and that, I think, is the bottom line.

Mr. ARCHER. Mr. Chairman, two principles have forever guided this great nation of ours—freedom and liberty. As a democratic nation whose strength is derived from its people, we have achieved unparalleled success, unsurpassed by any nation on this planet. It's no wonder that people around the globe want to come here and be called Americans. We're the envy of the world.

Our nation's health care system is no different. Americans don't travel abroad to get health care. Visitors come here—to the Mayo Clinic, to Mt. Sinai, to the Texas Medical Center, because we are the best.

And the reason our health care system is the best is because it's based on free-market principles, on choice and on individualism. But we lose that choice when we take it out of the hands of doctors and patients and put it in the laps of trial lawyers. As we consider a plan to protect and strengthen a free people who worry about the health care needs of themselves and their families, we must do so with our guiding principles in mind.

The best patient protection of all is health insurance, and the number one barrier to access to cost. But this big government approach makes this problem worse by raising the costs of health insurance premiums even higher, pricing thousands of American families out of the market. But Democrats don't stop there.

After they've raised health costs for Americans and made it more expensive for businesses to provide employees with health insurance, they want to pay for it by turning around and sticking it to those same companies under the guise of "closing loopholes." That's why the National Taxpayers Union and Americans for Tax Reform oppose the Democrats' one-two punch, because it slams the very people that create jobs and provide 70 percent of Americans with their health insurance.

Frivolous lawsuits won't promote individual choice. More trial lawyers won't mean better care. And higher punitive damages won't save one American from falling into the ranks of the uninsured.

The best patient protections we can offer to families and individuals is health care coverage. Forty-four million Americans go without that protection every day. Isn't it time we did something for them, and not the special interests? The American people want the choice and freedom to be examined by a doctor in the treatment room, not cross-examined by an attorney in the courtroom.

Finaly, Mr. Chairman, let me point out that the base bill and the amendments made in order under the rule address tax matters under the jurisdiction of the Committee on Ways and Means.

Specifically, section 401 of H.R. 2723, as introduced, contains a single tax code amendment to enforce the legislation's so-called patient protections through the existing tax penalty structure in the tax code. The bill aims to conform to the structure established in the original HIPAA law by including health reforms in both the Public Health Service Act and ERISA, as well as by reference in the tax code. The Houghton substitute includes an identical provision.

Title III of the Boehner substitute and Title III of the Goss substitute include similar provisions necessary to mirror the proposed health reforms in the tax code. However, these two amendments have been drafted to more closely follow the format used in the HIPAA legislation.

Mr. COX. Mr. Chairman, my colleagues today are addressing very real concerns that patients and doctors have raised. The current system of ''managed care'' imposes restrictions on a patient's choice of doctors. It interferes with the doctor-patient relationship. And it requires patients to navigate through a maze of frustrating health care bureaucracy. Indeed, the only dysfunction the current system does not yet suffer from is an epidemic of litigation that drives up health care costs. More lawsuits is not the right prescription for today's health care ailments. Rather, we need more consumer choice. Choice, quality, and competition should be the watchwords of this debate.

In a competitive market, when consumers don't like what they want, they go elsewhere. In today's health care market, where employers often provide only one health care plan to employees, that is often not possible. Workers who are dissatisfied with their HMO care should have real alternatives to choose from, not just a lawsuit against a plan they didn't really want to begin with.

Today, 90 percent of insured Americans are covered through their employers. Fully 30 percent of employers provide only one health plan to their employees. And a whopping 70 percent offer only no more than two choices. The tragic cause of Americans' lack of health care choice is federal regulation. The tax code provides a special break for employer-provided third-party payment plans. It provides a severe disincentive for individuals to shop for their own insurance, fee-for-service medicine, or other health care not preapproved by Uncle Sam. As a result, individuals are left with a Hobson's choice—employer-provided coverage or nothing. When your employer contracts with an HMO provider, what choice do you have?

Today's bill piles on more regulation and litigation on top of this tragic mess. It further regulates how you interact with your HMO. It does not increase individual choice; it only increases the cost of health care for everyone. Increased health care costs, in turn, mean rationing of services, limits on patient choice, shortages of the latest high-tech equipment, and long waiting lists for operations. Consumers will see an increase in premiums, and many will lose their benefits or their insurance altogether as employers are forces to drop coverage due to higher costs.

It's time to give Americans more choice in their health care, and more control over their health care dollars. Instead, however, this bill takes us towards more and more government control.

Until individuals have an alternative to an employer-provided HMO, the fool's gold of ever-increasing litigation and regulation will beckon us toward disaster. The solution is to resist the calls for more lawsuits and more government controls, and to move to a genuinely competitive market that will empower consumers, put patients and doctors back together and cut out the bureaucracy, deliver reduced costs, provide increased access, and guarantee improved health care quality.

Ms. PELOSI. Mr. Chairman, there are few things more important to family security than access to quality health care. People's health must come before the corporate bottom line. We must preserve and protect the doctor-patient relationship, and put health care providers ahead of insurance company accountants. At least 13 million Californians and 122 million Americans are now without enforceable patient protections on their health care plans. To protect them, Congress must act to pass a real Patients' Bill of Rights.

Take, for example, the person who has a painful health condition. Her doctor would like to prescribe a medication with the fewest side effects, but that drug is not on the managed care company's formulary. Or consider a person with a chronic disease who needs frequent access to a specialist, but is required to get a referral from his primary care doctor for each specialty visit.

H.R. 2723, the Norwood-Dingell Patients' Rights Bill, would provide needed protections for these and other health care consumers. The bill would: ensure access to emergency care without prior authorization; allow people to choose their own primary care and specialty providers; and give patients the right to hold HMO's accountable.

The other bills we will consider today fall far short of guaranteeing many important protections. H.R. 2824, introduced by Representatives COBURN and SHADEGG, and H.R. 2926, introduced by Representative BOEHNER, differ from the Consensus bill in important ways. In particular, they would not provide patients with the ability to hold health plans accountable in state courts, which typically handle injury and wrongful death suits, and are less expensive and more accessible than federal courts.

Mr. Chairman, last week we learned that the number of the uninsured in this country has increased to over 44 million. For years, many of my colleagues and I have insisted that we must expand access to health care. But H.R. 2290, the Quality Care for the Uninsured Act, would institute untested or failed health programs and cost at least $48 billion over ten years.

For example, ''Association Health Plans'' authorized in the bill would repeal state-based health care reform initiatives that address the needs of local consumers, and eliminate several consumer protections designed to prevent fraud and abuse. H.R. 2290 would undermine our ability to pass comprehensive and bipartisan patient protection this year. It should be rejected by the House.

The Bipartisan Consensus Managed Care Improvement Act provides a broad range of important protections for health care consumers. The American Medical Association has stated that the bill is ''the only real patients' bill of rights,'' and the Children's Defense Fund feels that the legislation is ''tailored to meet the health care needs of children and their families.'' I urge my colleagues to support real patient protection by voting for H.R. 2723.

Ms. MILLENDER-McDONALD. Mr. Chairman, our day has been consumed with debate on a desperate rule drafted to derail the bipartisan managed care reform train. This disheartens me because the Norwood-Dingell bill is a good bill. It is such a good bill; the three alternatives have used it as their base. Why is that? Whatever the reasons may be, they are all for naught if this good bill has to be joined with the poison pill train that the Rules Committee placed on our tracks.

The Norwood-Dingell bill allows women to obtain routine ob/gyn care for their ob/gyn without prior authorizations or referral. This is a good step in the right direction.

Mr. Chairman, this bill needs a straight up or down vote. When a straight up or down vote—without poison pills is allowed, I urge my colleagues to vote YES on the Norwood-Dingell bill.

Mr. KUCINICH. Mr. Chairman, I rise in favor of this bill. If HMOs are left free to determine the quality and availability of health care in America, they will have an incentive to deny care to those who need it and reward their executives and shareholders with these quote unquote ''savings''. Studies show that HMO enrollees receive ⅓ less home visits after a hospital stay (1994 Health Care Finance Review study). HMO enrollees are three times more likely to report problems getting medical care than publicly owned and managed Medicare beneficiaries (1969 Study by the Physician Payment Review Commission, a Congressional advisory commission). Meanwhile, private HMO executives are richly-compensated. The total cash compensation received by the CEOs of just the 3 largest HMO companies totaled 33.3 million dollars. Three companies: Aetna, Inc.—$888,568, Pacifi Care Health System Inc.—$1.7 million, Oxford Health Plans—$30.7 million.

Now, our job in Congress is to pass laws. But what good is a law that is not enforced? The easiest way for HMOs to limit health care costs is to deny people care to those who need it most. This bill gives citizens the opportunity to hold HMOs accountable for trimming costs at the expense of the sick. If a lawsuit against an HMO corrects the incentives and ensures that the best treatment will be given to a patient rather than the cheapest treatment, then I say, give people their day in court to enforce the law. And what we really need is a national health care system so that every person has health care coverage and has protected rights under the law. Let's pass H.R. 2723, I urge my colleagues to vote ''yes'' on this bill.

Mr. KLECZKA. Mr. Chairman, the need for managed care reform is clear.

According to a study by the non-partisan Kaiser Family Foundation, nearly nine in 10

doctors say their patients had experienced denial of coverage by a health maintenance organization (HMO) over the past two years. The same study found that as many as two in three of those doctors believe that the denial resulted in a serious decline in health for their patients.

To address this problem, the bill before us today, the Managed Care Patients' Bill of Rights, will establish critical patient protections to ensure that consumers get the health care they've been promised and have paid for.

The Patients' Bill of Rights would: prohibit plans from gagging doctors who wish to talk about treatment options; ban arrangements in which doctors receive incentives to limit medically necessary service; prevent plans from retaliating against health care workers who advocated on behalf of their patients; allow women to see their OB/GYN without prior approval; allow patients to select pediatricians as the primary care provider for children; allow patients with special needs to get a standing referral to a specialist; require coverage of emergency care without prior approval; and allow patients with life-threatening conditions access to approved clinical trials.

None of these provisions have any weight unless patients can hold health plans accountable for the medical decisions they make. This bill would allow patients to do so.

Some insurance companies, business groups and their advocates in Congress claim that if you hold health plans accountable in the courts for their actions the whole health care system will collapse. They say there will be a rush to the courthouse and the cost of health care will shoot through the roof. This is just not so.

For those who claim the sky is falling, let me point to an article that appeared in the Washington Post. As this article explains, two years ago, Texas became the first state to give patients the ability to sue their health plan. Since then, there have been only five lawsuits among the over 4 million Texans who belong to HMOs. Moreover, health care premiums have not increased more in Texas than in the rest of the country.

The Dingell-Norwood bill would ensure that all Americans have the protections which have worked to promote better patient care in Texas. The bill would permit patients—or their survivors—to sue their health plans in state courts when they make negligent decisions that result in injury or death.

H.R. 2723 is a responsible approach to make our nation's health plans accountable for their actions. As a cosponsor of the Dingell-Norwood Managed Care Patients' Bill of Rights, I stand in strong support of this needed reform which will finally put patient protections ahead of special interests.

Mr. WELDON of Florida. Mr. Chairman, I rise in support of the Norwood-Dingell bill, H.R. 2723. I am very supportive of the provisions in this bill which strengthen patient protections and restore the doctor-patient relationship.

I am also hopeful that the final bill that we send to a House-Senate conference will include not only the Norwood-Dingell patient protections, but also provisions that will make health insurance more affordable for the growing ranks of the uninsured. Our failure to address both of these issues will leave the job perilously half done.

I fully support the strong patient protection standards included in H.R. 2723, many of which were included in my Access to Specialty Care legislation from the last Congress. Particularly, I am pleased that the bill provides for a strong internal and external review process. This will help reassure patients that medical decisions about their coverage have received full consideration, not only by an internal board of medical experts, but also by an external board of medical experts.

The bill also ensures that patient have access to the care they need in a timely manner. In addition to providing timely internal and external reviews, the bill ensures that patients' emergency room expenses are covered. For a patient to be second guessed by a health plan administrator after an emergency episode is unreasonable. H.R. 2723 ensures that patients have their emergency health care needs taken care of. It also ensures that they have greater access to the specialty care that they need. This is critical for ensuring that patients have access to the type of provider that can care for their special needs.

In addition to these provisions, I am pleased that the bill ensures that women can designate an obstetrician or gynecologist as their primary care provider. Also, I am pleased that we ensure that parents can designate a pediatrician as the primary care provider for their children. These provisions make perfect sense and they will be of significant help in emphasizing preventive care.

The bill will also ensure that health plan enrollees will have access to full, easily understandable language on what medical services are covered and not covered. Information is the key to empowering individuals to make informed decisions on their health care. Consumers should have a right to know before they sign up with a plan exactly what is covered and what is not covered.

I am pleased with provisions that will ensure that no one gets between the physician and the patient. The patient must have the assurance that their physician is not influenced by any third party when making decisions about their health care. Toward this end, the bill eliminates gag rules that in the past have limited the free speech of doctors when talking with their patients. Additionally, the bill ensures that the insurance companies are no longer permitted to offer perverse incentives that would encourage health care providers not to provide care.

Finally, H.R. 2723 includes liability provisions to hold medical decisionmakers accountable. While I agree that the current system in which the people who make medical decisions to deny care are often not held accountable, I am concerned that the provisions in the Norwood-Dingell bill go too far. I fully support provisions to hold health plans accountable for the decisions they make; however, we must ensure that we do not open Padora's Box by turning the Patients' Bill of Rights legislation into a Lawyers Right to Bill. Any liability legislation must impose caps.

We must recognize that allowing trial lawyers and their clients to walk away with multimillion dollar awards will raise everyone's premiums. The costs of multi-million dollar lawsuit awards will be passed along to everyone in higher premiums to health plan enrollees. That is why I believe it is critical that if the final bill includes liability provisions, we must insist on reasonable caps on damages. While caps may not be in the best interest of the trial lawyers, it is important for average American citizens in ensuring that insurance premiums are more affordable.

Mr. UDALL of Colorado. Mr. Chairman, I rise in opposition to H.R. 2990 and in favor of the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act.

At some time in their lives, all Americans will be faced with making tough choices about medical care for themselves or their families. At these times, the last thing anyone wants to think about is whether their health plan will pay for what's necessary. H.R. 2723 is a bipartisan solution to many of the problems Americans face with their health plans. The bill creates new federal standards and requirements on all health insurance plans and would cover 161 million Americans, much more than what is covered in the Senate bill.

I believe H.R. 2723 would protect the doctor-patient reationship. It provides a point of service option if the enrollee otherwise does not have access to non-network alternatives. It provides access to emergency room care, specialists, and clinical trials. It gives women their choices of OB/GYN specialists without referrals from a primary care provider. It allows parents to choose a pediatrician as their child's primary care physician. It provides for continuity of care in cases where a provider or insurer is terminated by a plan.

And finally, it will give consumers uniform grievance and appeals procedures, including the right to sue, if their health plan makes a decision that puts them in harms way.

In short, this legislation will help restore the doctor-patient relationship, give Americans better access to care, greater consumer information, and better protections and benefits. On top of all this, it protects employers by exempting them from legal action if they are not involved in a claim decision.

H.R. 2723 is good legislation. It is good for Americans, and it is good for the future health of our country.

The CHAIRMAN. All time for general debate has expired.

Mr. THOMAS. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. KUYKENDALL) having assumed the chair, Mr. HASTINGS of Washington, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2723) to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage, had come to no resolution thereon.

APPOINTMENT TO BOARD OF TRUSTEES OF THE AMERICAN FOLKLIFE CENTER

The SPEAKER pro tempore. Without objection, and pursuant to section 4(b) of Public Law 94–201 (20 U.S.C. 2103(b)), the Chair announces the Speaker's appointment of the following individuals from private life to the Board of Trustees of the American Folklife Center in the Library of Congress on the part of the House: