

agency had been transferring technology to Iran to allow Iran to build a medium-range missile partly based on the Russian SS-4 missile.

What does this mean, Mr. Speaker? This means that within 12 months, Iran will have a medium-range missile that can hit any one of 25,000 American troops that this President today has deployed in Bosnia, in other regions around the Middle East, Somalia, Macedonia, because of the capability of those missiles. It also means that Iran will be able to hit, from its homeland, Israel directly with a medium-range missile.

It means that Iran is working, as well as Iraq, on developing medium-range missile capabilities that is going to destabilize that part of the world. And the horror story here, Mr. Speaker, is we will have no system in place to defend Israel against those missiles when they are deployed.

Now, some say we have the Patriot system. It was great during Desert Storm. The Patriot system was not designed to take out missiles. It was built as a system to shoot down airplanes. When the risk of Saddam's Scud missiles appeared in Desert Storm, Raytheon Corporation was able to heat up that Patriot system to give us some capability to take out low-complexity Scud missiles. But our military has acknowledged publicly that during Desert Storm, the Patriot system was at best 40 percent effective, which meant that 60 percent of the time we could not take out those Scud missiles. And even when we did hit the Scud missile, we were not hitting the warhead where a chemical or biological weapon would be. We were hitting the tail section, so that the debris would actually land on the people and still do the devastating damage of the bomb or the weapon of mass destruction and have its impact on the people whom it was intended to hurt.

In fact we had our largest loss of life of American troops in this decade in Dhahran, Saudi Arabia, when that low-complexity Scud missile went into that barracks.

The point reinforces my notion, Mr. Speaker. While we need to continue to control the amount of defense spending, we need to be prepared for what is happening in the world today. China is spending a larger and larger amount of its money on defense. North Korea has now deployed a medium-range missile that we thought we would not see for 5 years. It is called the No Dong. It now threatens all of Japan. It threatens South Korea, and potentially troops in that theater, and they are working on a longer-range missile that eventually will be able to hit Alaska and Hawaii.

The point is that as much as we want to spend more and more money on domestic programs, we cannot do that by sacrificing the strong deterrent that a strong military provides. The reason we have a strong military is not just to fight wars. It is to deter aggression. There has never been a nation that has

fallen because it is too strong. And while we do not want to be the bully of the world, we need to understand that strength in our military systems deters regional aggression. And regional aggression is what leads to larger confrontations and eventually world war.

Here is a summary, Mr. Speaker, of the budget projections from 1991 to 2001. The blue bar graph is mandatory outlays. They are going to increase by 35 percent during that 10-year period. The green bar graph is domestic discretionary spending. That is going to increase by 15 percent during the 10-year period. The red bar graph is defense spending. It is decreasing by 35 percent during that 10-year time period.

We need to be careful, Mr. Speaker, that we do not approach a similar situation to what occurred in the 1970s, because if we allow our military to not modernize, to not provide the support for the morale of the troops, we could begin to see a decay that we will not be able to reverse.

Now, why is all of this important and why do I discuss it today? Because the budget problems that I outlined at the beginning of my special order are going to be exacerbated after the turn of the century. This administration has postponed all modernization in our military and, therefore, everything has been slid until the next administration comes into office. This administration looks great. They have been able to balance the budget, they have been able to cut spending. They say they have cut Federal spending. They have only cut defense. That is the only area of the Federal Government where we have had real decline in real terms.

□ 2230

But in the process of doing that, they have postponed decisions for new systems until the next century. In the year 2000 and beyond, these are the systems that are currently scheduled by this administration to go into full production: the V-22 for the Marine Corps; the Comanche for the Army; the F-22 for the Air Force; the F/A-18E and F for the Navy; the Joint Strike Fighter for the Navy, Air Force, and Marine Corps; a new aircraft carrier; new destroyers.

The Army after next, an information-controlled Army; missile defense, theater missile defense, national missile defense. All of these programs, Mr. Speaker, are coming on line at the beginning of the next century and none of them can be paid for because of what we are doing to the defense budget today.

Now, what have I proposed? I have told the administration, cut more programs. If you are not going to cut environmental costs, if you are not going to reduce deployments, if you cannot close more bases, and if you are not going to give us more money for defense, then cancel more programs.

I voted to cancel the B-2, and the President kept the line open one more year during his election year in spite of

the fact that we should have canceled it and saved that money. And I told the administration, cancel one of the tactical aviation programs. We cannot build three new TACAIR programs. This year we are spending \$2.7 billion on tactical aviation that is buying new fighter planes.

The current plans of this administration in building the F-22, the Joint Strike Fighter, and the F/A-18E and F, the GAO and CBO estimate in 10 years would cost us between 14 and 16 billion dollars a year. Where does this President think he is going to get—he is not going to be here. Where does he think the next President is going to get an increase of \$10 to \$12 billion just for tactical fighters alone? It is not going to happen, Mr. Speaker.

That is why I am predicting a major train wreck, a train wreck that could jeopardize security of this country. We have got to be realistic about what the threats are. We have got to be realistic about what our needs are. We have got to be realistic about the way that we prioritize spending. We have got to be honest with the American people. And we have not done this.

This administration in the State of the Union speech two months ago mentioned national security out of an 80-minute speech in two sentences. Yet the President is quick to deploy our troops around the world, but does not want to fund the dollars to support those very troops and modernize them.

Something has got to give, Mr. Speaker. And I hope this special order tonight will make our colleagues, will make this city, and will make this country understand the dilemma we are facing. I am not here to advocate massive increases in defense spending. I am here to say help us control the amount of money we are currently putting forth, cut where we can, be realistic about what the threats are, and be honest about what our needs are in the 21st century. Because if we do not do that, I think the prospects for the long-term security of this country and the free world get dimmer and dimmer.

#### HMO CARE

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

Mr. GANSKE. Mr. Speaker, 2 years ago I met a woman who killed a man. I did not meet her in prison. She was not on parole. She had never even been investigated by the police. In fact, for causing the death of a man, she received congratulations from her colleagues and she moved up the corporate ladder. This woman, Dr. Linda Peeno, was working as a medical reviewer at an HMO.

In testimony before the Committee on Commerce on May 30, 1996, she confessed that her decision as an HMO reviewer to deny payment for a life-saving operation led to the preventable

death of a man she had never seen. Dr. Peeno then exposed the ways that HMOs denied payment for health services. She showed how plans draft contract language to restrict access to benefits. She showed how HMOs cherry-pick healthy patients. She showed how HMOs use technicalities to deny necessary medical care.

Dr. Peeno also told Congress about the most powerful weapon in an HMO's arsenal to hold down costs. HMOs generally agree to cover all services that are deemed medically necessary. But because that decision is made by HMO bureaucrats, not by the treating physician, Dr. Peeno called it the "smart bomb" of cost containment.

Hailed initially as a great breakthrough in holding down health costs, the painful consequences of the managed care revolution are being revealed. Stories from the inside, like those told by Dr. Peeno, are shaking the public's confidence in managed care. We can now read about some of Dr. Peeno's experiences in the March 9 edition of U.S. News and World Report.

The HMO revelations have gotten so bad that health plans themselves are running ads touting the fact that they are different from the bad HMOs that do not allow their subscribers a choice of doctors or interfere with their doctors practicing good medicine.

Here in Washington one ad says, "We don't put unreasonable restrictions on our doctors. We don't tell them that they cannot send you to a specialist." This Chicago Blue Cross ad proclaims, "We want to be your health plan, not your doctor." In Baltimore, the Preferred Health Network ad states, "At your average health plan, cost controls are regulated by administrators. APHN doctors are responsible for controlling costs."

This goes to prove that even HMOs know that there are more than a few rotten apples in the barrel. The HMO industry has earned a reputation with the public that is so bad that only tobacco companies are held in lower esteem. Let me cite a few statistics.

A national survey shows that far more Americans have a negative view of managed care than a positive view. By more than 2-to-1, Americans support more government regulation of HMOs. The survey shows that only 44 percent of Americans think managed care is a good thing.

Do my colleagues want proof? Well, recently I saw the movie "As Good As It Gets." When Academy Award winner Helen Hunt expressed an expletive about the lack of care her asthmatic son gets from their HMO, people clapped and cheered. It was by far the biggest applause line of the movie. No doubt the audience's reaction has been fueled by dozens of articles and news stories highly critical of managed care and also by real-life experiences.

In September 1997, the Des Moines Register ran an op-ed piece entitled "The Chilly Bedside Manner of HMOs" by Robert Reno, a Newsweek writer.

Citing a study on the end-of-life care, he wrote, "This would seem to prove the popular suspicion that HMO operators are heartless swine."

The New York Post ran a week-long series on managed care; headlines included, "HMOs Cruel Rules Leave Her Dying for the Doc She Needs."

Another headline blared out, "Ex-New Yorker Is Told, Get Castrated In Order To Save." Or this one: "What His Parents Didn't Know About HMOs May Have Killed This Baby." Or how about the 29-year-old cancer patient whose HMO would not pay for his treatments? Instead, the HMO case manager told the patient to "hold a fund-raiser," a fund-raiser. Mr. Speaker, I certainly hope that campaign finance reform will not stymie this man's chance to get his cancer treatment.

To save money, some HMOs have erected increasingly steep barriers to proper medical care. These include complex utilization review procedures, computer programs that are stingy about approving care, medical directors willing to play fast and loose with the term "medically necessary."

Consumers who disagree with these decisions are forced to work their way through Byzantine appeals processes which usually excel at complexity, but generally fall short of fairness; and these appeals, unfortunately, Mr. Speaker, can last longer than the patient. The public understands the kind of barriers they face in getting needed care.

Republican pollster Frank Luntz recently held a focus group in Maryland. Here is what some consumers said. One participant complained, "I have a new doctor every year." Another said she is afraid that if something major happened "I wouldn't be covered." A third attendee griped that he had to take off work twice because the plan requires people to see the primary care doctor before seeing a specialist.

Those fears are vividly reflected in editorial page cartoons. Here is one that reflects what the focus group was talking about. It shows a woman working in a cubicle in a claims department of an HMO. In talking with the customer she remarks, "No, we don't authorize that specialist. No, we don't cover that operation. No, we don't pay for that medication. No, we don't consider this assisted suicide." These HMO rules create ethical dilemmas.

A California internist had a patient who needed emergency treatment because of fluid buildup in her lungs. Under the rules of the patient's plan, the service would come at a hefty cost to the patient. She told the doctor that she could not have the treatment because she did not have the money. However, if she was admitted to the hospital, she would have no charges. So her doctor bent the rules. He admitted her and then he immediately discharged her.

Now, Mr. Speaker, are HMOs now forcing doctors to lie for their patients? HMOs have pared back benefits

to the point of forcing Congress to get into the business of making medical decisions. Take, for example, the uproar over the so-called drive-through deliveries. This cartoon shows that some folks thought health plans were turning their maternity wards into fast food restaurants. As the woman is handed her new child, the gate keeper at the drive-through window asks, "Would you like fries with that?"

Well, in a case that is not so funny, in 1995 Michelle and Steve Bauman testified before the Senate about their daughter, Michelina, who died two days after she was born. Their words were powerful and eloquent. Let me quote from Michelle and Steve's statement. "Baby Michelina and her mother were sent home 28 hours after delivery. This was not enough time for doctors to discover that Michelina was born with streptococcus, a common and treatable condition. Had she remained in the hospital an additional 24 hours, her symptoms would have surfaced and professional trained staff would have taken the proper steps so that we could have planned a christening rather than a funeral. Her death certificate listed the cause of death as meningitis." Michelle and Steve went on to say, "when it should have read, death by the system."

In the face of scathing media criticism and public outrage, health plans insisted that nothing was wrong, that most plans allowed women to stay at least 48 hours and that babies discharged the day of delivery were just as healthy as others.

Mr. Speaker, that line of defense sounds a lot like the man who was sued for causing an auto accident. "Your Honor, he says, I was not in the car that night. But even if I was, the other guy was speeding and swerved into my lane."

□ 2245

For expectant parents, however, the bottom line was fear and confusion. There is nothing more important to a couple than the health and safety of their child. Because managed care failed to condemn drive-through deliveries, all of us are left to wonder whether our plans place profits ahead of care. The drive-through delivery issue is hardly the only example of the managed care industry fighting to derail any consumer protection legislation. What makes this strategy so curious is that most plans had already taken steps to guarantee new moms and infants 2 days in the hospital. Sure, there were some fly-by-night plans that might not have measured up, but most responsible plans had already reacted to the issue by guaranteeing longer lengths of stay. The HMOs' efforts to reassure the public that responsible plans do not force new mothers and babies out of the hospital in less than 24 hours, however, were completely undermined by their opposition to a law ensuring this protection to all Americans. That was a missed

opportunity for the responsible HMOs to get out front, to proactively work for legislation that reflected the way they already operated. Not only would it have improved managed care's public image, but it would have given them some credibility.

Why then did managed care oppose legislation on this issue? Because the HMO industry is Chicken Little. Every time Congress or the States propose some regulation of the industry, they cry, "The sky is falling, the sky is falling." I would suggest that by endorsing some common sense patient protections, managed care would be more believable when they oppose other legislation.

Mr. Speaker, today's managed care market is highly competitive. Strong market rivalry can be good for consumers. When one airline cuts fares, others generally match the lower prices. In health care when one plan offers improved preventive care or expanded coverage, other market participants may follow suit. But the competitive nature of the market also poses a danger for consumers. In an effort to bolster profits, plans may deny coverage of care that is medically necessary. Or they may gag their doctors to cut costs. Some health plans have used gag rules to keep their subscribers from getting care that may save their lives.

During congressional hearings 2 years ago, we heard testimony from Alan DeMeurers who lost his wife Christy to breast cancer. They are pictured here with their children. When a specialist at UCLA recommended that Christy undergo bone marrow transplant surgery, her HMO leaned on UCLA to change its medical opinion. Who knows whether Christy would be with her two children today had her HMO not interfered with her doctor-patient relationship. HMO gag rules have even made their way onto the editorial pages. Here is one such cartoon. A doctor sits across the desk from a patient and remarks, "I'll have to check my contract before I answer that." Dr. Michael Haugh is a real life example of this problem. He testified before the Committee on Commerce and told how one of his patients was suffering from severe headaches. He asked her HMO to approve a specific diagnostic procedure. They declined to cover it, claiming that magnetic resonance arteriogram was experimental. Remember, Dr. Peeno testified about the clever ways that health plans decide not to cover requested care. So Dr. Haugh explained the situation in a letter to his patient. In it he wrote, "The alternative to the MRA is to do a test called a cerebral arteriogram which requires injecting dye into the arteries and carries a much higher risk to it than MRA. It is because of this risk that I am writing to tell you that I still consider that an MRA is medically necessary in your case." Two weeks later, the medical director of BlueLines HMO wrote to Dr. Haugh. He said, "I consider your letter to the member to be significantly in-

flammatory. You should be aware that a persistent pattern of pitting the HMO against its member may place your relationship with BlueLines HMO in jeopardy. In the future I trust you will choose to direct your concerns to my office rather than in this manner."

Amazing. The HMO was telling this doctor that he could not express his professional medical judgment to his patient. Cases like these and others demonstrate why Congress needs to pass legislation like the Patient Right to Know Act to prevent health plans from censoring exam room discussions. This gag rule cartoon is even more pointed. Once again a doctor sits behind a desk talking to a patient. Behind the doctor is an eye chart saying "ENUF IZ ENUF." The doctor looks at a piece of paper and tells his patient, "Your best option is cremation, \$359, fully covered," and the patient says, "This is one of those HMO gag rules, isn't it, Doctor?"

The HMO industry continues to fight Federal legislation to ban gag rules. The HMOs and their minions in Congress still keep the Patient Right to Know Act from coming to the floor, despite the fact that it has been cosponsored by 299 Members of this House, endorsed by over 300 consumer and health profession organizations and has already been enacted to protect those receiving services under Medicare and Medicaid, but not for those of you who are not poor or elderly. Even some executives of managed care plans have privately told me that they are not opposed to a ban on gag rules, because they know that competition can result in a race to the bottom in which basic consumer protections are undermined.

My bill to ban gag rules presents managed care with an opportunity to be on the vanguard of good health care. Instead, they are frittering away another opportunity just like they did with drive-through deliveries. In opposing a ban on gag rules, HMOs have only fueled bipartisan support for broader, more comprehensive reform legislation.

In recognition of problems in managed care, last September three managed care plans joined with consumer groups to announce their support of an 18-point agenda. Here is a sample of the issues that the groups felt required nationally enforceable standards, things like guaranteeing access to appropriate services, providing people with a choice of health plans, ensuring the confidentiality of medical records, protecting the continuity of care, providing consumers with relevant information, covering emergency care, disclosing loss ratios, banning gag rules. These health plans and consumer groups wrote, "Together we are seeking to address problems that have led to a decline in consumer confidence and trust in health plans. We believe that thoughtfully designed health plan standards will help to restore confidence and ensure needed protection." Mr. Speaker, I could not have said it better myself. These

plans, including Kaiser Permanente, HIP, the Group Health of Puget Sound probably already provide patients with these safeguards. So it would not be a big challenge for them to comply with nationally enforceable standards. By advocating national standards, these HMOs distinguish themselves in the market as being truly concerned with the health of their enrollees. Noting that they already make extensive efforts to improve their quality of care, the chief executive officer of Health Insurance Plan, known as HIP said, quote, "Nevertheless, we intend to insist on even higher standards of behavior within our industry and we are more than willing to see laws enacted to ensure that result." Let me repeat that. "We are more than willing to see laws enacted to ensure that result."

One of the most important pieces of their 18-point agenda is a requirement that plans use a lay person's definition of emergency. Too often health plans have refused to pay for care that was delivered in an emergency room. The American Heart Association tells us that if we have crushing chest pain, we should go immediately to the emergency room because this could be a warning sign of a heart attack. But sometimes HMOs refuse to pay if the patient tests normal. If the HMO only pays when the tests are positive, I guarantee you, Mr. Speaker, people will delay getting proper treatment for fear of a big bill and they could die if they delay diagnosis and treatment. Another excuse HMOs use to deny payment for ER care is the patient's failure to get preauthorization. This cartoon vividly makes the point.

Kuddlycare HMO. My name is Bambi. How may I help you?

You're at the emergency room and your husband needs approval for treatment?

Gasping, writhing, eyes rolled back in his head? Doesn't sound all that serious to me.

Clutching his throat? Turning purple? Um-huh. Have you tried an inhaler?

He's dead? Well, then he certainly doesn't need treatment, does he?

Gee, people are always trying to rip us off.

Does this cartoon seem too harsh? Ask Jacqueline Lee. In the summer of 1996, she was hiking in the Shenandoah Mountains when she fell off a 40-foot cliff, fracturing her skull, her arm and her pelvis. She was airlifted to a local hospital and treated. You will not believe this. Her HMO refused to pay for the services because she failed to get preauthorization. I ask you, what was she supposed to do with broken bones lying at the base of the cliff? Call her HMO for preauthorization? I am sad to say that despite strong public support to correct problems like these, managed care regulations still seem stalled here in Washington. Some opponents of legislation insist that health insurance regulation, if there is to be any at all, should be done by the States.

Other critics worship at the altar of the free market and insist its invisible hand can cure the ills of managed care. As a strong supporter of the free market, I wish we could rely on ADAM SMITH's invisible hand to steer plans into offering the services consumers want. And while historically State insurance commissions have done an excellent job of monitoring the performance of health plans, Federal law puts most HMOs beyond the reach of State regulations. Let me repeat that. Federal law puts most HMOs beyond the reach of State regulations. How is this possible? More than two decades ago, Congress passed the Employee Retirement Income Security Act, which I will refer to as ERISA, to provide some uniformity for pension plans in dealing with different State laws. Health plans were included in ERISA, almost as an afterthought. The result has been a gaping regulatory loophole for self-insured plans under ERISA. Even more alarming is the fact that this lack of effective regulation is coupled with an immunity from liability for negligent actions. Mr. Speaker, personal responsibility has been a watchword for this Republican Congress. This issue is no different. I have worked with the gentleman from Georgia (Mr. NORWOOD) and others to pass legislation that would make health plans responsible for their conduct. Health plans that recklessly deny needed medical service should be made to answer for their conduct. Laws that shield them from their responsibility only encourage HMOs to cut corners.

Take this cartoon, for instance. With no threat of a suit for medical malpractice, an HMO bean counter stands elbow to elbow with the doctor in the operating room. When the doctor calls for a scalpel, the bean counter says, "pocket knife." When the doctor asks for a suture, the bean counter says, "Band-Aid." When the doctor says, "Let's get him to the intensive care unit," the bean counter says, "Call a cab."

Texas has responded to HMO abuses by passing legislation that would make ERISA plans accountable for improper denials of care. But that law is being challenged in court and a Federal standard is needed to protect all consumers. The lack of legal redress for an ERISA plan's act of medical malpractice is hardly its only shortcoming. Let me describe a few of ERISA's other weaknesses.

□ 2300

ERISA does not impose any quality assurance standards or other standards for utilization review. Except as provided in Kassebaum-Kennedy, ERISA does not prevent plans from changing, reducing or terminating benefits. With a few exceptions, ERISA does not regulate a plan's design or content, such as covered services or cost sharing. ERISA does not specify any requirements for maintaining plan solvency. ERISA does not provide the standards

that a State insurance commissioner would.

It seems to me that we can take one of three approaches in reforming the way health plans are regulated by ERISA. The first would be to do nothing, but I think I have already demonstrated why that is not acceptable.

The second option would be to ask the States to reassume the responsibility of regulating these plans. This was the traditional role of the States, and they continue to supervise other parts of the health insurance market. But I will tell you why that will not work.

Turning regulation of ERISA plans over to the States will be fought tooth and nail by big business and by HMOs, and it will not happen. That leaves only one viable option: some minimal reasonable Federal consumer health protections for patients enrolled in ERISA plans.

Now there are many proposals on the table, including the Patient Access to Responsible Care Act, the Patients' Bill of Rights, the 18-point agenda released by Kaiser HIP and AARP. Whether we enact one of these options or some other yet to be drafted, Congress created the ERISA loophole and Congress should fix it.

Now, defenders of the status quo sometimes say that making plans subject to increased State or Federal regulations is not the answer. They insist that like any other consumer good, managed care will respond to the demands of the market. I would note that other industries are liable for their acts of misconduct.

So the shield from liability provided by ERISA by itself distorts the health care market. It differs from a traditional market in other ways as well. For example, the person consuming health care is generally not paying for it. Most Americans get their health care through their employer because the primary customer, the one paying the bills, is the employer. HMOs have to satisfy their needs before they satisfy the needs of their patients. And the employer's focus on the cost of the plan may draw the HMO's attention away from the employee's desire for a decent health plan.

As Stan Evans noted in Human Events, many HMOs operate on a capitated basis. This means that plans are paid a flat monthly fee for taking care of you. This translates to the less they spend on medical services, the more profit they make.

Now, how many markets function on the premise of succeeding by giving consumers less of what they want?

Take a look at this cartoon which illustrates perfectly the problem of health plans focusing on the bottom line. The patient is in traction. This is the HMO bedside manner. And the doctor standing next to him says, "After consulting my colleagues in accounting we have concluded you are well enough. Now go home."

Are HMOs paying attention to their patients' health or to their stockholders' portfolios?

Stan Evans again hit the nail on the head when he noted:

Paid a fixed amount of money per patient regardless of the care delivered, HMOs have a powerful motive to deliver a minimum of treatment. Care denial, pushing people out of hospitals as fast as possible, blocking access to specialists and the like are not mistakes or aberrations. They stem directly from the nature of the setup in which HMOs make more money by delivering less care, thus pitting the financial interests of the provider against the medical interests of the patient.

His comment raises an important issue. Presented with tragedies like those of the Baumans or Mrs. DeMeurers, managed care defenders argue those are just anecdotes. What Mr. Evans points out is that cases like these are not mistakes or aberrations or anecdotes. They are exactly the outcomes we would expect in a system that rewards those who undertreat patients.

Finally, markets only function when consumers have real choices. Dissatisfied consumers have limited options. Most employers offer employees very few health plans. For many, the choice of their health plan is simple: Take it or leave it. Freedom in the health insurance market now means quitting your job if you do not like your HMO. There is not a free market when consumers cannot switch to a different health plan.

But even if we were to put aside all these arguments and assume that health insurance was a free market, there is still a need for legislation to guard patients from abuses. The notion of consumer protections is consistent and supportive in our concept of free markets. In his book, *Everything for Sale*, Robert Kuttner points out the problems of imperfect markets. He says:

Industries such as telecommunications, electric power and health care retain public purposes that free market forces cannot achieve. For example, as a society we remain committed to universal access for certain goods. Left to its own devices the free market might decide that delivering electricity and phone service to rural areas and poor city neighborhoods is just not profitable, just as the private market brands cancer patients as "uninsurable."

Think for a moment about buying a car. Federal laws ensure that cars have horns and brakes and headlights. Yet despite these minimum standards, we do not have a nationalized auto industry. Instead, consumers have lots of choices. But they know that whatever car they buy will meet certain minimum safety standards. You do not buy safety a la carte.

The same notion of basic protections and standards should apply to health plans. Consumer protections will not lead to socialized medicine any more than requiring seat belts has led to a nationalized auto industry. In a free market, these minimum standards set a level playing field that allows competition to flourish.

Critics of regulating managed care also complain that new regulations will drive up the costs of health insurance. In criticizing the Patient Access

to Responsible Care Act, they cite a study showing that certain provisions could increase health insurance premiums from 3 to 90 percent. Three to 90 percent. I mean, that is a joke. Such a wide range is meaningless. It must be an accountant's way of saying I do not know.

Other studies have said that costs may go up slightly, but nothing near the doomsday figures suggested by opponents of this legislation. A study by the accounting firm Muse and Associates shows that premiums will increase between seven-tenths of 1 percent and 2.6 percent if the Patient Access to Responsible Care Act is enacted.

And do not let the HMOs tell you that the rising premiums we are seeing this year are the result of Federal legislation. HMOs have been charging below cost premiums for a long time. As a result, we are now seeing premium increases long before passage of any Federal consumer protection legislation.

And keep in mind also the shareholder's philosophy of making money can come into conflict with the patient's philosophy of wanting good medical care. To save money, many plans have nonphysician reviewers to determine if callers requesting approval for care really need it. Using medical care cookbooks, they walk patients through their symptoms and then reach a medical conclusion.

These cookbooks do not have a recipe for every circumstance. Like the woman who called to complain about pain caused by the cast on her wrist. The telephone triage worker asked the woman to press down on her fingernail to see how long it took for the color to return. Unfortunately, the patient had polish on her nails.

How far can this go? Like this cartoon shows, pretty soon we could all be logging on to the Internet and using the mouse as a stethoscope.

This trend should trouble every one of us. Medicine is part science, part art. Computer operators cannot consider the subtleties of a patient's condition. Sometimes you can know the answer by reading a chart, but sometimes doctors reach their judgments by a sixth sense that this patient really is sick. There are certain things that computers just cannot comprehend.

Now doctors are expected to be professional, to adhere to standards and to undergo peer review. Most of all, they are expected to serve as advocates for their patients' needs, not to be government or insurance apologists. It is in the interests of our citizens that their doctor fights for them and not be "the company doc."

Like a majority of my colleagues, I am a cosponsor of H.R. 1415, the Patient Access to Responsible Care Act, otherwise known as PARCA. In an attempt to derail this legislation, the managed care community has made a number of false statements about this bill. For example, they repeatedly state that PARCA would force health

plans to contract with any provider who wanted to join its network. That is clearly a false statement. In two separate places in the bill, it states that it should not be considered an "any willing provider" bill.

PARCA simply includes a provider nondiscrimination provision similar to what was enacted in Medicare last year. Provider nondiscrimination and "any willing provider" are no more the same than equal opportunity and affirmative action.

Similarly, some opponents have suggested that the bill would force health insurance to be offered on a guaranteed issue or a community rated basis. This is a nonissue. Congressman Norwood and I oppose community rating and guaranteed issue and will not support any bill coming to the floor that would result in community rating or guaranteed issue.

□ 2115

Our goals should be passage of comprehensive patient protection legislation. I am committed to seeing legislation enacted before the close of the 105th Congress. I am open to working with all interested Members, Republican, and Democrat, to develop a bipartisan patient protection bill.

In the meantime, H.R. 586, the Patient Right to Know Act, which would ban gag rules, should be brought to the floor for a vote.

Mr. Speaker, just last week, a pediatrician told me about a 6-year-old child who had nearly drowned. The child was brought to the hospital and placed on a ventilator. The child's condition was serious. It did not appear that he would survive.

As the doctors and the family prayed for signs that he would live, the hospital got a call from the boy's insurance company. Home ventilation, explained the HMO reviewer, is cheaper than in-patient care. I was wondering if you had thought about sending the boy home.

Or consider the death of Joyce Ching, a 34-year-old mother from Fremont, California. Mrs. Ching waited nearly 3 months for an HMO referral to a specialist despite her continued rectal bleeding and severe pain. She was 35 years old when she died from a delay in the diagnosis of her colon cancer.

Joyce Ching, Christy DeMeurers, Michelina Baumann, Dr. Peeno's patient, Mr. Speaker, these are not just anecdotes. These are real people who are victims of HMOs.

Let us fix this problem. The people we serve are demanding it. Let us act now to pass meaningful patient protections. Lives, Mr. Speaker, are in the balance.

#### LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. GILLMOR (at the request of Mr. ARMEY) for today on account of emergency dental work.

Mr. McNULTY (at the request of Mr. GEPHARDT) for today after 2:00 p.m. on account of personal reasons.

Mr. YATES (at the request of Mr. GEPHARDT) for today after 4:30 p.m. on account of personal reasons.

#### SPECIAL ORDERS GRANTED

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

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

Ms. NORTON, for 5 minutes, today.

Ms. CARSON, for 5 minutes, today.

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

Mr. COBURN, for 5 minutes, today.

Mr. HULSHOF, for 5 minutes, on March 31.

Mr. HUNTER, for 5 minutes, today.

Mr. PETERSON of Pennsylvania.

Mr. BARR of Georgia, for 5 minutes, today.

Mr. GUTKNECHT, for 5 minutes, on March 27.

Mr. MICA, for 5 minutes, today.

The following Member (at her own request) to revise and extend his remarks and include extraneous material:

Mrs. CLAYTON for 5 minutes today.

#### EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

The following Members (at the request of Mr. PALLONE) and to include extraneous matter:

Mr. KIND.

Mr. ALLEN.

Ms. SANCHEZ.

Mr. VISCLOSKEY.

Ms. VELAZQUEZ.

Mr. FORD.

Mrs. MEEK of Florida.

Mr. KLECZKA.

Ms. MCCARTHY of Missouri.

Mr. DAVIS of Illinois.

Mr. STARK.

Mr. BORSKI.

Mr. TORRES.

Mr. VENTO.

Mr. FILNER.

The following Members (at the request of Mr. NETHERCUTT) and to include extraneous matter:

Mr. ROGERS.

Mr. DAVIS of Virginia.

Mrs. JOHNSON of Connecticut.

Mr. HORN.

Ms. ROS-LEHTINEN.

Mr. BILIRAKIS.

Mr. WICKER.

Mr. CALVERT.

Mr. EHRlich.

Mr. WALSH.

Mr. PAPPAS.

Mr. SMITH of New Jersey.

The following Members (at the request of Mr. GANSKE) and to include extraneous matter: