

KOLBE), my colleague. We have bipartisan support now for a proposal on Social Security that does what we say it will do. And people say, well, what do we say it will do? It goes a long way towards solving the long-term problems of Social Security, better than any other proposal out there.

And people say, "Well, CHARLIE, why are you so involved in Social Security?"

And I say two reasons. Their names are Chase and Cole. It is mine and my wife's 4-year-old and 2-year-old grandsons. I do not want them to look back 65 years from today and say, if only my granddad would have done what in his heart he knew he should have done when he was in the Congress, we would not be in the mess we are in today.

□ 2200

We have a wonderful opportunity, if we can find the bipartisan political courage to deal conservatively with this surplus, to avoid the temptation that some have today to spend the money, whether it be on tax cuts or whether it be on spending for new programs.

Members will see me up at this mike and at other mikes and using every possible opportunity over the next several days to encourage a majority of my colleagues to take this surplus and pay down the debt. Listen to what the American people are telling us in district after district. They are saying, pay down the debt.

Any small business man or woman knows what happens to their business when they get more debt than they can pay back. When the interest cost becomes insurmountable, an insurmountable problem to them, they understand. Why is it so difficult for Members of Congress to understand?

That is the message the Blue Dogs will be bringing. That is the message I hope we will find bipartisan support for.

#### URGING HOUSE LEADERSHIP TO BRING MANAGED CARE REFORM TO THE FLOOR FOR DEBATE

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

#### COMMONSENSE RECOMMENDATIONS ON THE BUDGET, THE BALANCED BUDGET ACT, AND MEDICARE

Mr. GANSKE. Mr. Speaker, I find myself agreeing with the gentleman from Texas (Mr. STENHOLM) on many of the issues that he has talked about regarding the budget. We are dealing primarily with what looks like a projected \$1 trillion surplus. That is assuming that we do not have a recession over the next 10 years, that the economy continues to be as strong, and

that we stay within budget caps related to the 1997 Balanced Budget Act.

But as my friend and colleague, the gentleman from Texas, rightly points out, I think we will need to go back and do some adjustments on the Balanced Budget Act, particularly as it relates to health care.

I have a lot of rural hospitals in my district, and there is a large teaching hospital in my State, just like there is in Texas, just like there is in every State in the country. Those rural hospitals and teaching hospitals over the next 4 or 5 years are going to lose millions and millions of dollars, and they will be in the red. We need to do something to adjust the payments, and we are not just talking about reductions in the rate of growth for their reimbursement, we are talking about a decrease, a real decrease and cuts from today.

For instance, the average rural hospital in the State of Iowa, my home State, currently gets paid by Medicare about \$1,200 for their costs for a patient who has a cataract operation. That is projected to decrease to about \$950 under the Balanced Budget Act. That is a real cut, that is not a reduction in the rate of growth. I could go through one procedure after another.

So when we look at the total budget, we have to also look at some adjustments that we are going to have to make in terms of Medicare. We are going to have to look at some real adjustments we are going to have to make in order to get our appropriations bills passed.

We cannot bring to the floor and expect it to pass a bill that would cut spending for the FBI by 20 percent. We cannot bring to the floor and expect the bill to pass if we would reduce funding for the immigration service, the INS, by 15 to 20 percent. That is a cut, not just reduce the rate of growth in their cost of living allowance. These are some real facts we are going to have to deal with.

Just like my friend, the gentleman from Texas, I think we ought to have a tax cut as well. But I cannot support an \$870 billion tax cut that we are talking about here in the House, not \$870 billion out of \$1 trillion in terms of the surplus.

I think it would be much more reasonable for us to sit down, reach across the aisle, reach down Pennsylvania Avenue, and come to an agreement. Let us do some adjustments on that Balanced Budget Act, maybe one-third of that surplus. Let us maybe do one-third of that surplus for a tax cut. That is still a hefty tax cut.

And let us do something that all of my constituents say we ought to do. For once, and it would probably be the first time in 50 or 60 years, let us actually reduce the Nation's debt. Let us do some real deficit reduction. I got elected in 1994 and took office in 1995. The

debt has increased every year since I have been in Congress. We have an opportunity this year to actually reduce the national debt.

What would be the benefit of that? Well, it would help reduce interest rates for everyone in the country. That makes a big difference if one is paying for a house or buying a car. By reducing that total debt that the country has, which is over \$5 trillion, by reducing that now, it gives us some cushion for what we will have to spend later on when the baby boomers retire.

Those are just some commonsense recommendations to my colleagues on both sides of the aisle.

Mr. Speaker, I want to talk primarily tonight about managed care reform. So I find myself standing on the floor yet again calling for comprehensive patient protection to be debated on the floor of the House of Representatives as soon as possible.

By the way, Mr. Speaker, do Members know the difference between a PPO, an HMO, and the PLO? At least, Mr. Speaker, with the PLO, you can negotiate.

Mr. Speaker, the clock continues to tick on our legislative calendar. So I ask, for the hundredth time, when are we going to debate comprehensive managed care legislation on the floor of the House of Representatives, and will the debate be fair? And when will the House Committee on Commerce mark up a managed care reform bill?

The decision was made to let the Committee on Education and the Workforce take up the comprehensive patient protection legislation first, but they are stalled. Nothing has happened in the Committee on Commerce, and nothing is happening in the other committees.

How can any of us say that we are making a strong effort to address managed care reforms when the Committee on Commerce, the committee of primary jurisdiction, has yet to hold a markup session on a managed care bill?

Before I go any further, I want to commend my colleagues, the gentleman from Georgia (Mr. NORWOOD) and the gentlewoman from New Jersey (Mrs. ROUKEMA), for their strong advocacy of strong patient protection legislation in the Committee on Education and the Workforce.

My colleagues have pointed out that the bills of the Committee on Education and the Workforce that were touted to be comprehensive managed care bills were, in reality, nothing more than an assurance of business as usual for the HMOs. Actually, they were not even business as usual, as those bills from the Committee on Education and the Workforce actually make it harder for patients to fight HMO abuses under the Employee Retirement Income Security Act, ERISA.

Mr. Speaker, I have spoken many times on this floor about how important it is for patients to have care that

fits what are called "prevailing standards of medical care." This issue is being debated here on Capitol Hill this week by the other body. It is a very, very important issue. So I want to spend a little bit of time to talk to my colleagues about this issue.

Mr. Speaker, many health plans devise their own arbitrary guidelines and definitions for "medical necessity." For example, one HMO defines "medical necessity" as the cheapest, least expensive care, without any qualification ensuring that patients will still receive quality health care coverage.

We might ask, how is it that HMOs are allowed to do that? That is not the case for the majority of insurance companies who sell to individual people. They have to follow State insurance laws. Under current Federal law, if you or a member of your family is insured by your employer in a self-insured plan, your employer can define "medical necessity" as anything that they want to. Furthermore, they are not liable for their decisions, except insofar as to give care that could be denied.

ERISA was originally designed as a consumer pension bill. It was designed to make pension plans uniform for employees, to make it easier for employers to issue pensions. It got extended to health plans sort of by a quirk 25 years ago. It was not even hardly debated here on the floor.

It did not make that much difference for a long time, when most health plans were traditional indemnity insurance plans. Then along came managed care. What happened? Those companies started making medical decisions. Then we started to run into the problems and the complications of those medical decisions.

Listen to some words that a former HMO reviewer gave as she testified before Congress. It was May 30, 1996, when this small, nervous woman testified before the Committee on Commerce. Her testimony came after a long day of testimony on the abuses of managed care.

This woman's name was Linda Peeno. She was a claims reviewer for several health care plans. She told of the choices that plans are making every day when they determine the medical necessity of treatment options.

I am going to recount her testimony: "I wish to begin by making a public confession." This is this HMO medical reviewer's words. "In the spring of 1987, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred. I was rewarded for this," she said. "It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do what was expected of me, I exemplified the good company medical reviewer. I saved the company half a million dollars."

As I was watching this lady testify, I could see that she was anguished. Her voice was husky. She was tearful. I looked around the room, and the audience shifted uncomfortably. They drew very quiet as her story unfolded. The industry representatives, the HMO representatives who were in that committee room, they averted their eyes.

She continued: "Since that day, I have lived with this act and many others eating into my heart and soul. For me, a physician is a professional charged with the care of healing of his or her fellow human beings. The primary ethical norm is do no harm. I did worse. I caused death."

She continued, "Instead of using a clumsy, bloody weapon, I used the cleanest, simplest of tools: My words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for the moment. When any moral qualms arose, I was to remember, I am not denying care, I am only denying payment."

She continued: "At that time, that helped me avoid any sense of responsibility for my decisions. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize that action."

□ 2215

I accept my responsibility now for that man's death as well as for the immeasurable pain and suffering many other decisions of mine caused.

Well, at that point Ms. Peeno described many ways managed care plans deny care, but she emphasized one in particular: The right to decide what care is medically necessary. She said, quote, "There is one last activity that I think deserves a special place on this list, and this is what I call the "smart bomb" of cost containment, and that is medical necessity denials. Even when medical criteria is used, it is rarely developed in any kind of standard traditional clinical process. It is rarely standardized across the field. The criteria are rarely available for prior review by the physicians or the members of the plan. And we have enough experience from history to demonstrate the consequences of secretive unregulated systems that go awry."

Well, Mr. Speaker, the room was stone quiet. The chairman of the committee mumbled "thank you." This medical reviewer could have rationalized her decisions as so many have done. She could have said, "I was just working within guidelines" or "I was just following orders." We have heard that one before. Or, "We have to save resources." Or, "Well, this is not about treatment, it is really about benefits."

But this HMO reviewer refused to continue this type of psychological denial and she will do penance for her

sins the rest of her life. And to atone for that she is exposing the dirty little secret of HMOs determining medical necessity.

Mr. Speaker, if there is only one thing my colleagues learn before voting on patient protection legislation, I beg them to listen to the following: before voting on any patient protection legislation, keep in mind the fact that no amount of procedural protection or schemes of external review can help patients if insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage. As Ms. Peeno so poignantly observed, insurers now routinely make treatment decisions by determining what goods or services they will pay for.

Let me give an example of how they can arbitrarily determine medical necessity. There is a health plan out there that determines medical necessity by defining it as: The cheapest, least expensive care as determined by us. So well, what could be wrong with that? What is wrong with the cheapest, least expensive care?

Well, before I came to Congress and in some surgical trips that I make abroad I still do this, I took care of a lot of children with cleft lips and palates. Let me show the birth defect of one of these children. This is a little baby born with a complete cleft lip and palate. This occurs about one in 500 births, so it is pretty frequent. A huge hole right in the middle of the face. Imagine being a mom or dad and giving birth to a little baby with this birth defect, and then think of that HMO that defines medical necessity as the cheapest, least expensive care.

Mr. Speaker, the prevailing standard of care, a standard that we have used in this country for over 200 years, would say the prevailing standard of care to fix this defect in the roof of this child's mouth is a surgical operation to fix that. I have done hundreds of those operations. That is the standard care everywhere in the world. However, that HMO, by its contractual language, can say but the cheapest, least expensive care would be to use what is called a plastic obturator. It would be like an upper denture plate. That way the food will not go up into the roof of the mouth, up into the nasal passages so much.

Of course, with that little plastic device which would be the cheapest, least expensive care, the child will probably never speak as good as if the child had a surgical correction of this birth defect. But so what does the HMO care? They are increasing their bottom line, their profits. And furthermore, under Federal law they can define it any way they want to by their contractual language if one happens to get their insurance from an employer.

Mr. Speaker, I think that is a tragedy. I think that is a travesty. Congress created that law 25 years ago

never expecting that this type of behavior would be done by HMOs. Yet 50 percent of the reconstructive surgeons who take care of children with this birth defect have had HMOs deny operations to surgically correct this condition by calling them, quote, "cosmetic operations."

This is not a cosmetic operation. Cosmetic operations are repairing baggy eyelids or a face lift. This is a birth defect. Prevailing standards of care would say surgical correction, not a piece of plastic shoved up into the roof of a patient's mouth with food and fluid coming out of their nose.

Who would do that, some would ask? Well, it happens. And we need to fix the Federal law that keeps that happening. What else about that Federal law needs to be fixed? Well, over the last few days I have watched the debate up here on the Hill in the other body. There was an amendment that dealt with who would be covered by patient protection legislation. The GOP bill would only cover about one quarter of the people in this country. There was an amendment to make it cover everyone in this country, these patient protections. Getting up and arguing against it were my GOP colleagues by saying, hey, we should not interfere with the States's ability, States's rights, let the States decide this. The only problem with this is that it is Federal law that has exempted State regulation and State oversight.

I want to see in a few days if my colleagues will talk the same tune when we are talking about liability. It was Federal law that gave a liability shield to HMOs so that if they do negligent, malicious behavior that results in injury, loss of limb, or death that they are not responsible.

Let me give an example of what I am talking about in terms of what HMOs have done. This is the case of a little 6-month-old boy. A little 6-month-old boy in Atlanta, Georgia, actually lives south of Atlanta, Georgia, woke up one night crying about 3:00 in the morning and had a temperature of 104 and looked really sick. His mother thought he needed to go to the emergency room. This is this little boy tugging on his sister's sleeve before his HMO health care. So his mother phoned the 1-800 number and she is told, "We will authorize you to go to an emergency room, but we will only let you go to this one hospital a long ways away. And if you go to a nearer one, we will not cover it."

So Dad gets in the car, Mom wraps up little Jimmy and they start on their trek. About halfway through the trip, they pass three hospital emergency rooms. Mom and Dad are not health professionals. They know Jimmy is sick but they do not know how sick, but they do know if they stop without an authorization, they could get stuck with thousands of dollars of bills be-

cause their HMO will not pay for it. So they push on to that one authorized hospital.

What happens? En route, little Jimmy's eyes roll back in his head, he stops breathing, he has a cardiac arrest. Picture Mom and Dad, Dad driving like crazy, Mom trying to keep her little infant alive to get to the emergency room. Somehow or other they manage to get to the emergency room. Mom holding little Jimmy leaps out the car screaming, "Help my baby, help my baby." A nurse comes out and starts to give mouth-to-mouth resuscitation. They bring out the crash cart and get him intubated and get the lines going and give him medicines and somehow or other this little baby lives. But he does not live whole.

Because he has had that cardiac arrest en route to the hospital, the only one authorized by that HMO which has made that medical decision, he ends up with gangrene of both hands and both feet and both hands and both feet have to be amputated.

Here is little Jimmy today. I talked to his mom about 6 weeks ago. Jimmy is learning to put on his leg prostheses with his arm stumps. He still cannot get on his bilateral hook prostheses for his hands by himself. Jimmy will never play basketball. He will certainly never wrestle. And some day when he gets married, he will never be able to caress the face of the woman that he loves with his hand.

Mr. Speaker, under Federal law if one's little baby had this happen to them and their insurance was from their employer who had a self-insured plan and their plan had made that decision, that negligent decision which had resulted in this disaster, under Federal law that plan would be liable for nothing other than the cost of the amputations.

Is that fair? Is that the way it is if one buys insurance as an individual from a plan that is covered by State regulation? No. So, Mr. Speaker, I would say to my colleagues, my colleagues in the other body and my colleagues in this body, when we get a chance to vote on whether health plans ought to be liable for decisions that they make that result in this type of negligence, a judge reviewed this case. A judge looked at the case. He said that the margins of safety by this HMO were, quote, "razor thin." I would add to that, about as razor thin as the scalpels that had to remove little Jimmy's hands and feet.

Mr. Speaker, I say to my friends on both sides of the aisle and in the other body, when we get a chance to vote on whether a health plan should be responsible for their actions that result in this type of injury, think, especially my fellow Republicans, think about how we always say as Republicans, hey, people should be responsible for their actions. Do not we say that? If some-

body is able-bodied and they can work, they ought to be responsible for providing for their family? Do not we say that if somebody kills somebody or is a rapist that they ought to be responsible for their criminal behavior?

How can we then say that an HMO which makes this type of decision that results in this type of injury should not also be responsible? There is no other entity, no other business, no other individual in this country that has that type of legal protection. It is wrong. It should be fixed.

The State of Texas fixed this 2 years ago. They made their health plans liable. Now, of course this is being challenged because of the ERISA law. But since that time there has not been an explosion of lawsuits. There has only been one. I will read about it in a few minutes. But why has there not been? Because health plans suddenly realized that they cannot cut corners like they did with this little boy or they are going to be liable. They are going to be responsible.

□ 2230

Did it significantly increase premiums in Texas? No. Premiums in Texas have not gone up any higher than they have anywhere else in the country. Did it mean that managed care would die out in Texas? No. Several years ago, there were 30 HMOs in Texas. Today, there are 51. That law is working. It did not result in a huge number of lawsuits, and it has not resulted in a big increase in premiums like all the HMOs would have us believe.

Let me read today an editorial from USA Today. The title of this is, "Why should law protect HMOs that injure patients?"

Last July, Joseph Plocica's health plan discharged him from a hospital, against the advice of his psychiatrist, who said the Fort Worth resident had suicidal depression requiring continued help, according to a lawsuit. That night, Plocica proved his doctor right and his health plan wrong. He drank a half-gallon of antifreeze and died 8 days later.

As terrible as this story is, at least Plocica's bereaved family has more rights than most. A sweeping 1997 Texas law let them sue Plocica's health plan for malpractice.

That's a right denied to the roughly 120 million other Americans who receive their health care through work. This week, the federal law that protects those health plans from lawsuits is the focus of a contentious Senate debate over patients' rights.

The central question: Should HMOs, which often make life and death decisions about treatments, be legally accountable when their decisions go tragically wrong?

Like Mr. Plocica who drank antifreeze or little Jimmy here who lost his hands and feet.

"Right now", the USA Today editorial continues,

the answer is no, although that is a luxury no doctor, and no other business, enjoy.

The provision might have made sense when it was passed by Congress in 1974 as part of a law designed to protect workers' pensions. Most employees were covered by old-style fee-for-service insurance plans and payment disputes took place after health care had been delivered. So a law limiting recovery to the cost of care did not hurt anybody. But today, more than 80 percent of workers are in managed care plans that actively direct what treatments parents received.

Unfortunately, despite efforts in Texas and a few other states to find ways around this law, the gaping liability loophole is not likely to be closed nationwide any time soon unless Congress acts.

Insurance and business groups have mounted an aggressive fight against a version of the Patients' Bill of Rights that allows patients to sue. They say opening up HMOs to lawsuits will result in a flood of litigation and kill cost control by doing little to improve quality care.

But in Texas, where these same groups made all the same arguments, the reality is far from different.

No flood of lawsuits. Only a handful of cases have been filed against HMO plans in Texas since the challenge to the law was overturned last fall. This is due, in part, to another feature of that 1997 law, which requires swift independent review of disputes.

Rates have not shot up. In the two years since the law was passed, HMO premiums in the state are almost exactly where they stood in 1995. Cost increases in Dallas and Houston were below the national average last year.

Quality may be improving. News accounts from Texas suggests that HMOs, now accountable for their decisions, are more careful making

those decisions.

Doctors report health plans are less likely to drag their feet, for instance, and less likely to deny treatments doctors believe are needed.

There's no reason to believe a national law would produce any different results, continues this editorial.

Studies by the Congressional Budget Office and the nonprofit Kaiser Family Foundation find HMO liability would produce negligible premium hikes. Only industry-sponsored studies find otherwise.

Lawmakers would do well to look at the facts before leaving this critical patient right on the cutting room floor.

Mr. Speaker, I do not think we should hesitate about having HMOs be responsible, despite the fact that the HMO industry has spent more than \$100,000 per Congressman lobbying against a strong Patients' Bill of Rights. Surveys show that, despite all that advertising, that money spent on advertising by the insurance and HMO industry for the last 2 years, there has been no significant change in public opinion about the quality of HMO care.

Despite tens of millions of dollars of advertising, a recent Kaiser survey shows no change in public opinion: 77 percent favor access to specialists, 83 percent favor independent review, 76 percent favor emergency room coverage, 70 percent favor the right to sue one's HMO. Other surveys show that 85 percent of the public think Congress should fix these HMO abuses.

If these concerns are not addressed, I think the public will see examples like this, and they will ultimately reject the market model as it now exists. However, if we can enact true managed care reform such as that embodied by my own Managed Care Reform Act of 1999 or the Dingell or the Norwood bills, then consumer rejection of a market model will be less likely.

Common sense, responsible proposals to regulate managed care plans are not a rejection of the market model of health care. In fact, they are just as likely to have the opposite effect. They will preserve the market model by saving it from its own most irresponsible and destructive tendencies.

Mr. Speaker, let us pass real HMO reform. Let us learn from States like Texas. After all, is it not Republicans who often say that the States are the laboratories of democracy? Yes, let us have some insurance tax incentives. But let us be very careful about repeating some mistakes that have been made with ERISA in the past that led to fraud in regards to association health plans.

Finally, the Speaker of the House told me before the July 4th recess that it was his intent to have HMO reform legislation on the floor by the middle of July. Well, Mr. Speaker, here we are. According to my watch, it is now the middle of July, and we have no date yet even for a full committee mark-up in the House of Representatives. Why? Well because it is not clear that another HMO protection bill could make it through committee. Too many Republicans and Democrats of each committee want to see some real reform to prevent this type of tragedy, real reform, not a fig-leaf piece of legislation.

I think there are even majority votes in both the Committee on Education and the Workforce and the Committee on Commerce for strong medical necessity and enforcement measures. Maybe that is the reason why the committee chairmen are not moving ahead. Maybe that is why the leadership of this House is not telling them to get their act in order, get this to the floor.

Well, the Senate is debating HMO reform this week. So let us see what happens there.

I think today the Washington Post called it about right when it referenced the GOP Senate bill. It said, "The Republican bill professes to provide many of the same protections, but the fine print often belies its claims. Among much else, it turns out to apply only to some plans and to only about one-fourth as many people as the Democratic bill would cover."

The Post then talked about the GOP criticisms of the Democratic bill, "Critics say that the Democratic bill, by weakening the cost-containment industry, would drive up costs." The Post continues, "Our contrary sense is that, in the long run, it would strengthen

cost containment by requiring that it be done in a balanced way", exactly the sentiments that I expressed a few minutes ago.

Today the Washington Post closed that editorial by saying, "The risks of increased costs tend to be exaggerated in debate. The managed care industry says that, by and large, it already does most of the modest amount this bill would require of it. If so, the added cost can hardly be as great as the critics contend."

Mr. Speaker, when we are talking about the cost for a strong Patients' Bill of Rights, we are talking about something in the range of \$36 per year for a family of four. Is that not worth it to prevent an HMO tragedy like happened to this little boy?

Mr. Speaker, please keep your promise. By next week, we should have debated HMO reform in full committee, and we should be headed to the floor. Is that going to be the situation? Or is it the Speaker's intention to try to limit debate on this important issue by putting it right up against August recess, when Members have planned vacations with their families, in order to limit debate.

Well, Mr. Speaker, if that is so, it will be seen for what it really is, a cynical abuse of scheduling because the leadership of this House really does not want a full debate on protecting patients. Mr. Speaker, I hope that is not the case. The victims of managed care and their families are watching.

#### ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. GARY MILLER of California). The Chair will remind all Members to refrain from references to the Senate including the characterization of Senate action and the urging of the Senate to take certain action.

#### LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Ms. BALDWIN (at the request of Mr. GEPHARDT) for today after 5:30 p.m. and Wednesday, July 14 when on account of illness in the family.

Mr. HASTINGS of Florida (at the request of Mr. GEPHARDT) for today on account of official business.

Mrs. THURMAN (at the request of Mr. GEPHARDT) for today on account of illness in the family.

#### 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:)