

from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committees on Armed Services and the Committee on International Relations and ordered to be printed:

*To the Congress of the United States:*

In accordance with the provisions of section 1512 of Public Law 105-261, the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, I hereby certify that the export to the People's Republic of China of satellite fuels and separation systems for the U.S.-origin Iridium commercial communications satellite program:

(1) is not detrimental to the United States space launch industry; and

(2) the material and equipment, including any indirect technical benefit that could be derived from such export, will not measurably improve the missile or space launch capabilities of the People's Republic of China.

WILLIAM J. CLINTON.

THE WHITE HOUSE, May 10, 1999.

#### ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain special order speeches without prejudice to the resumption of legislative business.

#### ON HEALTH CARE

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

Mr. GANSKE. Mr. Speaker, I have taken to the well of this Chamber many times to talk about the need to enact meaningful patient protection legislation. Unfortunately, there remains a compelling need for Federal action, and I am far from alone in holding that view.

Last week, for example, Paul Elwood gave a speech at Harvard University on health care quality. Elwood isn't exactly a household name, but he is considered the father of the HMO movement.

Elwood told a startled group that he did not think health care quality would improve without government-imposed protections. Market forces, he told the group, "will never work to improve quality, nor will voluntary efforts by doctors and health plans."

Mr. Elwood went on to say, and I quote, "It doesn't make any difference how powerful you are or how much you know. Patients get atrocious care and can do very little about it. I've increasingly felt we've got to shift the power to the patient. I'm mad, in part because I've learned that terrible care can happen to anyone."

This is a quote by Paul Elwood, the father of the American HMO movement. Mr. Speaker, this is not the commentary of a mother whose child was injured by her HMO's refusal to authorize care. It is not the statement of a doctor who could not get requested treatment for a patient. Mr. Speaker, these words suggesting that consumers need real patient protection legislation to protect them from HMO abuses come from the father of managed care.

Mr. Speaker, I am tempted to stop here and to let Dr. Elwood's speaks for themselves, but I think it is important to give my colleagues an understanding of the flaws in the health care market that led Dr. Elwood to reach his conclusion.

Cases involving patients who lose their limbs or even their lives are not isolated examples. They are not anecdotes.

In the past, I have spoken on this floor about little Jimmy Adams, a 6-month-old infant who lost both hands and both feet when his mother's health plan made them drive many miles to go to an authorized emergency room rather than stopping at the emergency room which was closest.

The May 4 USA Today contains an excellent editorial on that subject. It is entitled, Patients Face Big Bills as Insurers Deny Emergency Claims.

After citing a similar case involving a Seattle woman, USA Today made some telling observations:

"Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford."

Or, "All patients are put at risk if hospitals facing uncertainty about payment are forced to cut back on medical care."

This is hardly an isolated problem. The Medicare Rights Center in New York reported that 10 percent of complaints about Medicare HMOs related to denials for emergency room bills.

The editorial noted that about half the States have enacted a "prudent layperson" definition for emergency care this decade, and Congress has passed such legislation for Medicare and Medicaid.

Nevertheless, the USA Today editorial concludes that this patchwork of laws would be much strengthened by passage of a national prudent layperson standard.

The final sentence of the editorial reads, "Patients in distress should not have to worry about getting socked with big health bills by firms looking only at their bottom line."

Mr. Speaker, I include the full text of the editorial in the RECORD at this point.

[From USA Today]

TODAY'S DEBATE: PAYING FOR EMERGENCY CARE—PATIENTS FACE BIG BILLS AS INSURERS DENY EMERGENCY CLAIMS

Our View—Industry Promises to Fix the Problem Fail, Investigations Begin

Early last year, a Seattle woman began suffering chest pains and numbness while driving. The pain was so severe that she pulled into a fire station seeking help, only to be whisked to the nearest hospital, where she was promptly admitted.

To most that would seem a prudent course of action. Not to her health plan. It denied payment because she didn't call the plan first to get "pre-authorized," according to an investigation by the Washington state insurance commissioner.

The incident is typical of the innumerable bureaucratic hassles patients confront as HMOs and other managed care companies attempt to control costs. But denial of payment for emergency care presents a particularly dangerous double whammy:

Patients facing emergencies might feel they have to choose between putting their health at risk and paying a huge bill they may not be able to afford.

All patients are put at risk if hospitals, facing uncertainty about payment, are forced to cut back on medical care.

Confronted with similar outrages a few years ago, the industry promised to clean up its act voluntarily, and it does by and large pay up for emergency care more readily than it did a few years ago. In Pennsylvania, for instance, denials dropped to 18.6% last year from 22% in 1996.

That's progress, but not nearly enough. Several state insurance commissioners have been hit with complaints about health plans trying to weasel out of paying for emergency room visits that most people would agree are reasonable—even states that mandate such payments. Examples:

Washington's insurance commissioner sampled claims in early 1998 and concluded in an April report that four top insurers blatantly violated its law requiring plans to pay for ER care. Two-thirds of the denials by the biggest carrier in the state—Regence BlueShield—were illegal, the state charged, as were the majority of three other plans' denials. The plans say those figures are grossly inflated.

The Maryland Insurance Administration is looking into complaints that large portions of denials in the state are illegal. In a case reported to the state, an insurance company denied payment for a 67-year-old woman complaining of chest pain and breathing problems because it was "not an emergency."

Florida recently began an extensive audit of the state's 35 HMOs after getting thousands of complaints, almost all involving denials or delays in paying claims, including those for emergency treatments.

A report from the New York-based Medicare Rights Center released last fall found that almost 10% of those who called the center's hotline complained of HMO denials for emergency room bills.

ER doctors in California complain the Medicaid-sponsored health plans routinely fail to pay for ER care, despite state and federal requirement to do so. Other states have received similar reports, and the California state Senate is considering a measure to toughen rules against this practice.

The industry has good reason to keep a close eye on emergency room use. Too many patients use the ER for basic health care when a much cheaper doctor's visit would suffice.