

Thank you, and God bless you. (Applause.)

**OPPOSE RENEWAL OF WHALING
BY MAKAH TRIBE**

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. METCALF) is recognized for 5 minutes.

Mr. METCALF. Mr. Speaker, I rise to speak on an issue that millions of our people in our Nation seriously care about. Since the close of the worldwide whaling era at the end of the last century, it has been U.S. policy to oppose killing whales.

But today we have a real problem. The Clinton-Gore administration is quietly changing this policy by authorizing the hunting and killing of whales by the Makah Indian tribe in north-west Washington State.

The victims of course are the gray whales, the major focus of whale watching on the northwest coast of Washington State and the United States. These whales are local to the northwest coast, and they do not fear boats. They are used to the boats. They see boats all the time, and they have no fear.

Whales do have a commercial value and there are interests just waiting to cash in, even as they did in the glory days of worldwide commercial whaling. If we allow whaling to begin in America again, what can we say to Japan and Norway whose whaling we have opposed for years? We tried to get them to stop. Now we are going to allow commercial whaling again.

The real problem is, once we open the door to new worldwide commercial whaling, how do we ever close it again? Most Americans believe that we have risen above the wanton slaughter of the buffalo for their hides or the whales for the value of their body parts.

□ 1615

I urge my colleagues to join me in opposition to the renewal of whaling by the Makah Tribe of Northwest Washington State.

**SAVE OUR CHILDREN FROM GUN
VIOLENCE**

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

Mrs. MCCARTHY of New York. Mr. Speaker, yesterday the Senate voted down a loophole that could have been closed as far as guns being sold at gun shows. This was a very moderate request so that people, people with felonies, criminals, could not go to gun shows and buy guns that could possibly be used or sold to our young people.

Last month when we had the shooting in Littleton, Colorado, it was some-

thing that all of us as victims were dreading. We always knew it was not a matter of if there would be another shooting in our schools, it all came down to a matter of when. How did I know that? I knew that because we have had five committee hearings here in the House. We have brought in all the experts. We were trying to analyze from the five shootings in our schools what could be done, what can we do.

After Littleton, the American people said, we have to do something, and yet we hear silence here in the halls of Congress and now, obviously, in the Senate. What people forget is that every single day in this country 13 of our young people die through homicide, accidental deaths and suicides. People forget about those young people on a daily basis. Here they say there is nothing we can do.

I do not believe that. I believe with sensible, moderate changes on how our young people get guns we can make a big difference. I know we will not be able to save all our children, but we certainly should do everything that we can to save as many as we can.

I also know if the American people, the mothers, the fathers, students, teachers, if they do not become involved in this debate, we will not do anything here in the House. There are many of us that want to fight to save our children, to make sure our children feel safe when they go to the schools, but we need help. We need help because we have to hear from the American people. We need grass-root organizations. We need people to call here in Congress, call their Senator, e-mail them and say, "We want something done."

When there is such a high percentage of Americans willing to make the sacrifice of being inconvenienced, inconvenienced to hopefully have more safety for our children, they are willing to do it. And yet those in the Senate and here in the House we hear nothing from. It is wrong.

All we want is to try and have safe schools, to save our children. That is something that we are supposed to be doing here. That is why I came to Congress, to reduce gun violence, not to take away the right of someone to own a gun. I have never intended that.

All I am saying is, if someone owns a gun, they are responsible for it and they have to make sure that our young people do not get into it.

I know everyone is talking about the media, videos, mental health. These are all important issues. But responsibility with the parents, that is important also. We can deal with all these things. We have all the information. Anyone can go to the Committee on Education and the Workforce, and we will give them all the information they need.

There was one thing in common in every single one of the school shoot-

ings, the easy access of guns to our young people. I do not know what it will take to have the Members here and the Senate wake up. I do not know what it will take. I dread what it might take.

We can make a difference. The American people have said enough is enough. We should listen to them.

Why won't this Congress listen to the American people and allow us to pass common sense laws to keep guns out of the hands of our children?

Instead of listening to the American people, the Senate listened to the NRA leadership. Instead of making the laws stronger to stop kids and criminals from buying guns, the Senate has made the laws weaker. As a mother, grandmother and Member of Congress, I am deeply saddened by the Senate's vote.

The American people don't want this to be about politics but that's exactly what it is. How many more children will have to die before Congress wakes up and passes laws to save young lives?

We will not give up. We will fight harder for what the American people want—common sense measures to keep guns away from our kids and off our school campuses. My office alone has heard from thousands of people throughout this country who support legislation to address the deadly combination of children and guns.

Now more than ever, we need to hear from every school and from every parent in this nation. Call, write, e-mail—flood the halls of Congress with your demands—let this Congress know that you want meaningful legislation passed to save our children from gun violence. Every day that goes by with more silence from this Congress, we lose 13 more kids.

CONSUMERS NEED PATIENT PROTECTION LEGISLATION TO PROTECT THEM FROM HMO ABUSES

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. There is 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. Paul Elwood is not a household name, but he is considered the father of the HMO movement. Elwood told a surprised 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 effort by doctors and health plans."

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 have increasingly felt we've got to shift the power to the patient. I'm mad, in part because I have learned that terrible care can happen to anyone."

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 his patient. No, Mr. Speaker, those words, suggesting that consumers need real patient protection legislation to protect them from HMO abuses, come from the father of managed care.

I am tempted to stop here and let Dr. Elwood's words speak 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 life are not isolated examples. Mr. Speaker, they are not mere anecdotes.

In the past, I have spoken about James Adams, an infant who lost both his hands and both his feet when his mother's health plan made them drive past one emergency room after another in order to go to an authorized emergency room. Unfortunately, enroute, James suffered an arrest, and because of that arrest he lost both hands and feet because of the delay in treatment.

On Monday, May 4, USA Today ran an excellent editorial on that subject. It was 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."

And this is hardly an isolated problem. The Medicare Rights Center in New York reported that 10 percent of complaints for Medicare HMOs related to denials for emergency room bills. The editorial noted that about half the States have enacted prudent layperson definitions for emergency care this decade, and Congress has passed such protection for Medicare and Medicaid recipients. Nevertheless, the USA Today editorial concludes that this patchwork of laws would be much strengthened by passage of a national prudent layperson standard that applies to all Americans.

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 this editorial for the RECORD:

[From USA Today, May 4, 1999]

PATIENTS FACE BIG BILLS AS INSURERS DENY EMERGENCY CLAIMS

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 that 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 that Medicaid-sponsored health plans routinely fail to pay for ER care, despite state and federal requirements 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.

But what's needed to address that is better patient education about when ER visits are

justified and better access to primary care for those who've long had no choice other than the ER, not egregious denials for people with a good reason to seek emergency care.

Since the early 1990s, more than two dozen states have tried to staunch that practice with "prudent layperson" rules. The idea is that if a person has reason to think his condition requires immediate medical attention, health plans in the state are required to pay for the emergency care. Those same rules now apply for health plans contracting with Medicare and Medicaid.

A national prudent layperson law covering all health plans would help fill in the gaps left by this patchwork of state and federal rules.

At the very least, however, the industry should live up to its own advertised standards on payments for emergency care. Patients in distress should not have to worry about getting socked with big health bills by firms looking only at their own bottom line.

Mr. Speaker, there are few people in this country who have not had difficulty getting health care from their HMO. Whether we are talking about extreme cases like little Jimmy Adams or routine difficulties in obtaining care that seem all too common, the public is getting frustrated by managed care. In fact, 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. By more than two to one, Americans support more government regulation of HMOs. Last month, the Harris Poll revealed that only 34 percent of Americans think managed care companies do a good job of serving their customers. That is down sharply from the 45 percent who thought that a year ago.

Maybe more amazing were the results when Americans were asked whether they trusted a company to do the right thing if they had a serious safety problem. By nearly two to one Americans would not trust HMOs in such a situation. That level of confidence was far behind other industries such as hospitals, airlines, banks, automobile manufacturers, and pharmaceutical companies. In fact, the only industry to fare worse than the managed care industry on the trust issue was the tobacco companies.

Anyone who still needs proof that managed care reform is popular with the public just needs to go to the movie "As Good As It Gets." Audiences clapped and cheered during the movie when Academy Award winner Helen Hunt expressed an expletive about the lack of care her asthmatic son was getting from their HMO. No doubt the audiences' reactions were fueled by dozens of articles and news stories documenting the problems with managed care.

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.

The New York Post ran a week-long series on managed care. Headlines included, "HMO's Cruel Rules Leave Her

Dying for the Doc She Needs." Another headline blared out, "Ex New Yorker is Told, Get Castrated So We Can Save Dollars." Or how about 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 bureaucrat told him to hold a fundraiser. A fundraiser. Mr. Speaker, this is about patient protections, not about campaign finance reform.

To counteract this, some health plans have even taken to bashing their own colleagues. Here in Washington one ad read: "We don't put unreasonable restrictions on our doctors. We don't tell them they can't send you to a specialist." In Chicago, Blue Cross ads proclaimed, "We want to be your health plan, not your doctor." In Baltimore, an ad for Preferred Health Network assured customers, "At your average health plan, cost controls are regulated by administrators. But at PHN, doctors are responsible for controlling costs."

Advertisements like these demonstrate that even the HMOs know that there are more than a few rotten apples at the bottom of that barrel.

□ 1630

In trying to stave off Federal legislation to improve health care quality, many HMOs have insisted that the free market will help cure whatever ails managed care.

And I am a firm believer in the free market, but the health care market is anything but a free market. Free markets generally are not dominated by third parties providing first-dollar coverage. Free markets generally do not reward companies who give consumers less of what they want. And free markets usually do not feature limited competition either geographically or because an employer offers them only one choice, take it or leave it.

The Washington Business Group on Health recently released its fourth annual survey report on purchasing value in health care. Here are a few examples of how the market is working: "To improve health care, 51 percent of employers," this is employers, "51 percent of employers believe cost pressures are hurting quality. In evaluating and selecting health plans, 89 percent of employers consider cost. Less than half consider accreditation status. And only 39 percent consider consumer satisfaction reports.

"Employees are given limited information about their health plans. Only 23 percent of companies tell employees about appeals and grievance processes. And in the last 3 years, the percentage of businesses giving employees consumer satisfaction results has dropped from 37 percent to 15 percent. Over half of employers offer employees an incentive to select plans with lower costs.

Only about 15 percent offer financial incentives to choose a plan with higher quality."

Mr. Speaker, the recent Court of Appeals decision in the case "Jones v. Kodak" demonstrates just how dangerous the "free market" is to health plan patients.

Mrs. Jones received health care through her employer, Kodak. The plan denied her request for in-patient substance abuse treatment, finding that she did not meet their protocol standards. The family took the case to an external reviewer who agreed that Mrs. Jones did not qualify for the benefit under the criteria established by the plan. But that reviewer observed that "the criteria are too rigid and do not allow for individualization of case management." In other words, the criteria were not appropriate for Mrs. Jones's condition.

So, in denying Mrs. Jones's claim, the 10th Circuit Court of Appeals held that ERISA, the Employment Retirement Income Security Act, does not require plans to state the criteria used to determine whether a service is medically necessary. On top of that, the court ruled that unpublished criteria are a matter of plan design and structure rather than implementation and, therefore, not reviewable by the judiciary.

Well, Mr. Speaker, the implications of this decision are breathtaking. "Jones v. Kodak" provides a virtual road map to enterprising health plans on how to deny payment for medically necessary care. Under "Jones v. Kodak" health plans do not need to disclose to potential or even current enrollees the specific criteria they use to determine whether a patient will get treatment. There is no requirement that a health plan use guidelines that are applicable or appropriate to a particular patient's case.

And most important to the plans, the decision assures HMOs that if they follow their own criteria, then they are shielded from court review. It makes no difference how inappropriate or inflexible those criteria can be since, as the court in "Jones" noted, this is a plan design issue and, therefore, not reviewable under ERISA.

Well, if Congress, through patient protection legislation, does not address this issue, many more patients will be left with no care and no recourse to get that care. "Jones v. Kodak" sets a chilling precedent, making health plans and the treatment protocols untouchable.

For example, a plan could promise to cover cleft lip surgery for those born with this birth defect but they could put, under "Jones," in undisclosed documents that the procedure is only medically necessary once the child reaches the age of 16 or that coronary bypass operations are only medically appropriate for those who have previously survived two heart attacks.

Logic and principles of good medical practice would dictate that is not sound health care. But the "Jones" case affirms that health plans do not have to consider good health care, all they have to look at is the bottom line.

Unless Federal legislation addresses this issue, patients will never be able to find out what criteria their health plan uses to provide care and external reviewers who are bound by current law will be unable to find out what those policies are and to reach independent decisions about the medical necessity of a proposed treatment using generally accepted principles of standards of care. And the Federal ERISA law will prevent courts from engaging in those inquiries, too.

The long and the short of the matter is that sick patients will find themselves without proper treatment and without recourse.

Mr. Speaker, I have introduced legislation, H.R. 719, the Managed Care Reform Act, which addresses the very real problems in managed care. It gives patients meaningful protections. It creates a strong and independent external review process. And it removes the ERISA shield which health plans have used to prevent State court negligence actions by enrollees who are injured as a result of the plan's negligence.

This bill has received a great deal of support and has been endorsed by consumer groups like the Center for Patient Advocacy, the American Cancer Society, the National Association of Children's Hospitals, the National Multiple Sclerosis Society.

It has also been supported by many health care groups, such as the American Academy of Family Physicians, whose members are on the front lines and who see how faceless HMO bureaucrats thousands of miles away, bureaucrats who have never even seen the patient, deny needed medical care because it does not fit their criteria.

I would like to focus on one small aspect of my bill, especially the way in which it addresses the issue of the Employment Retirement Income Security Act, ERISA. It is alarming to me that ERISA combines a lack of effective regulation of health plans with a shield for health plans that largely gives them immunity from liability for their negligent actions.

Mr. Speaker, personal responsibility has been a watchword for this Republican Congress, and this issue should be no different. Health plans that recklessly deny needed medical service should be made to answer for their conduct. Laws that shield entities from their responsibility only encourage them to cut corners. Congress created the ERISA loophole, and Congress should fix it.

My bill has a compromise on the issue of health plan liability. I continue to believe that health plans that make negligent medical decisions

should be accountable for their actions. But winning a lawsuit is little consolation to a family that has lost a loved one. The best HMO bill ensures that health care is delivered when it is needed. And I also believe that the liability should attach to the entity that is making that medical decision.

Many self-insured companies contract with large managed care plans to deliver care. If the business is not making those discretionary decisions, then in my bill, they would not face liability. But if they cross that line and determine whether a particular treatment is medically necessary in a given case, then they are making medical decisions and they should be held accountable for their actions.

However, to encourage health plans to give patients the right care without having to go to court, my bill provides for both an internal and an external appeals process that is binding on the plan.

Mr. Speaker, that is where it varies with what passed this House last year. Sure, there was an external appeals process in last year's bill, but it was not binding on the plan. An external review could be requested in my bill by either the patient or by the health plan.

I can see some circumstances where a patient is requesting an obviously inappropriate treatment, like laetrile for cancer, and the plan would want to take that case to an external review. That would back up their decision and it would give them an effective defense if they were ever dragged into court to defend that decision.

So when I was discussing this idea with the President of Wellmark Iowa Blue Cross/Blue Shield, he expressed support for the strong external review. In fact, he told me that his company is instituting most of the recommendations of the President's Commission on Health Care Quality and that he did not foresee any premium increases as a result. Mostly what it meant, he told me, was tightening existing safeguards and policies already in place.

This CEO also told me that he could support a strong independent external review system like the one in my bill. But he said, if we do not make that decision and we are just following the recommendation of that external review panel, then we should not be liable for punitive damages. And I agree with that.

Punitive damage awards are meant to punish outrageous and malicious behavior. If a health plan follows the recommendation of an independent review board composed of medical experts, it is tough to figure out how that health plan has acted with malice.

So my bill provides health plans with a complete shield from punitive damages if they promptly follow the recommendations of that external review panel. And that I think is a fair com-

promise to the issue of health plan liability.

I certainly suspect that Aetna wishes they had had an independent peer panel available, even with a binding decision on care, when it denied care to David Goodrich. Earlier this year, a California jury handed down a verdict of \$116 million in punitive damages to his widow, Teresa Goodrich. If Aetna or the Goodriches had had the ability to send the denial of care to an external review, they could have avoided the courtroom, but more importantly, David Goodrich probably would have received the care that he needed and he might still be alive today.

And that is why my plan should be attractive to both sides. Consumers get a reliable and quick external appeals process which helps them get the care they need. But if the plan fails to follow the external reviewer's decision, the patient can sue for punitive damages.

And health insurers whose greatest fear is that \$50 million or \$100 million punitive damages award can shield themselves from those astronomical awards but only if they follow the recommendations of an independent review panel, which is free to reach its own decision about what care is medically necessary.

Now, the HMOs say that patient protection legislation will cause premiums to skyrocket. There is ample evidence, however, that that is not the case.

Last year, the Congressional Budget Office estimated that a similar proposal, which did not include the punitive damages relief that is in my bill, would have increased premiums around 4 percent cumulative over 10 years. And when Texas passed its own liability law 2 years ago, the Scott and White health plan estimate, that premiums would have to increase just 34 cents per member per month to cover the costs.

Now, Mr. Speaker, those are hardly alarming figures. And the low estimate by Scott and White seems accurate since only one suit has been filed against a Texas health plan since that law was passed. That is far from the flood of litigation that the opponents to that legislation predicted. I have been encouraged by the positive response my bill has received, and I think that this is the basis for what could be a bipartisan bill this year.

In fact, the Hartford Courant, a paper located in the heart of insurance country, ran a very supportive editorial on my bill by John MacDonald.

□ 1645

Speaking of the punitive damages provision, MacDonald called it "a reasonable compromise" and he urged insurance companies to embrace the proposal as "the best deal they see in a long time."

Mr. Speaker, I ask that the full text of the editorial by John MacDonald be included in the RECORD at this point.

[From the Hartford Courant, Mar. 27, 1999]

A COMMON-SENSE COMPROMISE ON HEALTH CARE

(By John MacDonald)

U.S. Rep. Greg Ganske is a common-sense lawmaker who believes patients should have more rights in dealing with their health plans. He has credibility because he is a doctor who has seen the runaround patients sometimes experience when they need care. And he's an Iowa Republican, not someone likely to throw in with Congress' liberal left wing.

For all those reasons, Ganske deserves to be heard when he says he has found a way to give patients more rights without exposing health plans to a flood of lawsuits that would drive up costs.

Ganske's proposal is included in a patients' bill of rights he has introduced in the House. Like several other bills awaiting action on Capitol Hill, Ganske's legislation would set up a review panel outside each health plan where patients could appeal if they were denied care. Patients could also take their appeals to court if they did not agree with the review panel.

But Ganske added a key provision designed to appeal to those concerned about an explosion of lawsuits. If a health plan followed the review panel's recommendation, it would be immune from punitive damage awards in disputes over a denial of care. The health plan also could appeal to the review panel if it thought a doctor was insisting on an untested or exotic treatment. Again, health plans that followed the review panel's decision would be shielded from punitive damage awards.

This seems like a reasonable compromise. Patients would have the protection of an independent third-party review and would maintain their right to go to court if that became necessary. Health plans that followed well-established standards of care—and they all insist they do—would be protected from cases such as the one that recently resulted in a \$120.5 million verdict against an Aetna plan in California. Ganske, incidentally, calls that award "outrageous."

What is also outrageous is the reaction of the Health Benefits Coalition, a group of business organizations and health insurers that is lobbying against patients' rights in Congress. No sooner had Ganske put out his thoughtful proposal than the coalition issued a press release with the headline: Ganske Managed Care Reform Act—A Kennedy-Dingell Clone?

The headline referred to Sen. Edward M. Kennedy, D-Mass., and Rep. John D. Dingell, D-Mich., authors of a much tougher patients' rights proposal that contains no punitive damage protection for health plans.

The press release said: "Ganske describes his new bill as an affordable, common sense approach to health care. In fact, it is neither. It increases health care costs at a time when families and businesses are facing the biggest hike in health care costs in seven years."

There is no support in the press release for the claim of higher costs. What's more, the charge is undercut by a press release from the Business Roundtable, a key coalition member, that reveals that the Congressional Budget Office has not estimated the cost of Ganske's proposal. The budget office is the independent reviewer in disputes over the impact of legislative proposals.

So what's going on? Take a look at the coalition's record. Earlier this year, it said it was disappointed when Rep. Michael Bilirakis, R-Fla., introduced a modest patients'

rights proposal. It said Sen. John H. Chafee, R-R.I., and several co-sponsors had introduced a "far left" proposal that contains many extreme measures. John Chafee, leftist? And, of course, it thinks the Kennedy-Dingall bill would be the end of health care as we know it.

The coalition is right to be concerned about costs. But the persistent No-No-No chorus coming from the group indicates it wants to pretend there is no problem when doctor-legislators and others know better.

This week, Ganske received an endorsement for his bill from the 88,000-member American Academy of Family Physicians. "These are the doctors who have the most contact with managed care," Ganske said. "They know intimately what needs to be done and what should not be done in legislation."

Coalition members ought to take a second look. Ganske's proposal may be the best deal they see in a long time.

It is also important to state what this bill does not do to ERISA plans. It does not eliminate ERISA or otherwise force large, multi-State health plans to meet benefit mandates of each and every State.

Now, this is an exceedingly important point. Just 2 weeks ago, I had representatives of a major employer from the upper Midwest in my office. They urged me to rethink my legislation because they alleged it would force them to comply with benefit mandates of each State and that the resulting rise in costs would force them to discontinue covering their employees. Frankly, Mr. Speaker, I was stunned by their comments, because their fears are totally unfounded.

It is true that my bill would lower the shield of ERISA and allow plans to be held responsible for their negligence, but it would not—let me repeat, Mr. Speaker—it would not alter the ability of group health plans to design their own benefit package. I want to be totally clear on this. The ERISA amendments in my bill would allow States to pass laws to hold health plans accountable for their actions, but it would not allow States to subject ERISA plans to a variety of State benefit mandates.

Before closing, Mr. Speaker, I also want to address something that should not be in patient protection legislation. I am speaking specifically of extraneous provisions that could bog down the bill and severely weaken its chances for passage. In particular, there have been reports in the press and elsewhere that the managed care reform legislation will at some point be married with a bill to increase access to health insurance. Let me be clear about this. While I strongly believe that Congress should consider ways to make health insurance more affordable, it would be a tremendous mistake to try to join these two issues together. It would present too many opportunities for needed patient protections to become sidetracked in fights over tax policy or the future of the employer-based system.

There are many reforms to improve access to health care that I support. I have long advocated Medical Savings Accounts. In fact, Mr. Speaker, I wrote a White Paper about their potential benefits in 1995; and I was very pleased to see them created first for small businesses and the uninsured and then 2 years ago for Medicare recipients.

I also support changing the tax law so that individuals receive the same tax treatment as large businesses when buying health insurance. It does not make sense to me why a big business and its employees can deduct the cost of health benefits but an employee of a small company that does not offer health insurance has to pay all the cost with after-tax dollars.

But ideas like Association Health Plans, also known as Multiple Employer Welfare Associations, and HealthMarts could, in my opinion, destroy the individual market by leaving it with a risk pool that is sicker and more expensive.

Simply put, an Association Health Plan is a pool of individuals or employers who band together and form a group that self-insures. By doing so, they remove themselves from regulation by State insurance commissioners and instead subject themselves to regulation, or I would say lack of regulation, by the Federal ERISA law.

While Association Health Plans may provide a measure of efficiency for employers, they leave employees without any real safeguards against the less honorable practices of health insurers.

In a very real sense, ERISA remains the "wild west" of health care. Unlike State laws, which regulate quality, ERISA contains only minimal safeguards.

Among its many shortcomings, ERISA does not impose any quality assurance standards or other standards for utilization review. ERISA does not allow consumers to recover compensatory or punitive damages if a court finds against the health plan in a claims dispute. ERISA does not prevent health plans from changing, reducing or terminating benefits. And, with few exceptions, ERISA does not regulate the design or content, such as covered services or cost sharing, of a plan. Remember from the Jones case how important that issue can be. And ERISA does not specify any requirements for maintaining plan solvency.

I confess, I cannot understand why some Members would want to place more employees in health plans regulated by ERISA. If anything, we should be moving in the opposite direction and returning regulatory authority to State insurance commissioners.

In a letter to Congress in June, 1997, the American Academy of Actuaries wrote:

While the intent of the bill is to promote Association Health Plans as a mechanism for improving small employers' access to afford-

able health care, it may only succeed in doing so for employees with certain favorable risk characteristics. Furthermore, this bill contains features which may actually lead to higher insurance costs.

That letter is in reference to the bill that passed the House last year.

The Academy went on to explain how those plans could undermine State insurance reforms:

The resulting segmentation of the small employer group market into higher and lower cost groups would be exactly the type of segmentation that many State reforms have been designed to avoid. In this way, exempting them from State mandates could defeat the public policy purposes intended by State legislatures.

The Academy also pointed out that these plans "weaken the minimum solvency standards for small plans, relative to the insured marketplace, which may increase chances for bankruptcy and fraud."

These concerns were echoed in a jointly signed letter by the National Governors Association, the National Conference of State Legislatures, and the National Association of Insurance Commissioners. They argued that Association Health Plans, and I might add HealthMarts, "substitute critical State oversight with inadequate Federal standards to protect consumers and to prevent health plan fraud and abuse."

Mr. Speaker, attempting to attach Association Health Plans or HealthMarts to patient protection legislation poses two very real dangers. First, Association Health Plans undermine the insurance market and can leave consumers without meaningful protections from HMO abuses. Second, I am very concerned that the opposition to AHPs and HealthMarts, if they are added to a patient protect bill, will bog down patient protection legislation and lead it to suffer the same death that it did last year. In other words, Mr. Speaker, Association Health Plans, HealthMarts, these are real poison pills.

Mr. Speaker, on behalf of patients like Jimmy Adams, who lost his hands and feet because an HMO would not let his parents take him to the nearest emergency room, I promise that I will fight efforts to derail managed care reform by adding these sorts of untested and potentially harmful provisions to patient protection legislation. And I pledge to do whatever it takes to ensure that opponents of reform are not allowed to mingle these issues in order to prevent passage of meaningful patient protections.

Finally, Mr. Speaker, time is flying. It is already the middle of May. The gentleman from Virginia (Mr. BLLEY), the chairman of the Committee on Commerce, and the gentleman from Florida (Mr. BILIRAKIS) the chairman of the Subcommittee on Health, now have a draft of patient protection legislation prepared by the gentleman from

Oklahoma (Mr. COBURN), the gentleman from Georgia (Mr. NORWOOD) and myself. That draft should serve as the basis for the chairman's mark.

The American Medical Association has just written me a letter that contains high praise for this draft. Mr. Speaker, I ask that the full text of this letter be included in the RECORD at this point.

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, May 12, 1999.

Hon. GREG GANSKE,
Longworth House Office Building, House of
Representatives, Washington, DC

DEAR REPRESENTATIVE GANSKE: On behalf of the 300,000 physician and student members of the American Medical Association (AMA), I would like to thank you for your efforts in drafting a compromise patient protection package for the Commerce Committee. The draft proposal, developed by Representatives Tom Coburn, MD (OK) and Charles Norwood, DDS (GA), and you, is a significant milestone in the advancement of real patient protections through the Congress. We look forward to working with you to perfect the draft bill through the committee process and to pass a comprehensive, bipartisan patient protection bill this year.

It is imperative that a patient protection bill be reported out of committee and be considered on the floor prior to the July 4th recess. The AMA stands ready to help further advance these important patient protections through the committee process, the House floor and final passage.

The AMA applauds the inclusion of "medical necessity" language that is fair to patients, plans and physicians alike. We are particularly pleased with the non-binding list of medical necessity considerations that you have incorporated into the draft bill.

The AMA is pleased with the incorporation of the "state flexibility" provisions that allow patient protections passed by various states to remain in force. Allowing pre-existing patient protection laws to remain in force is critical to the success of federal patient protection legislation such as the draft bill.

The draft bill also offers patients a real choice by incorporating a "point of service" option provision. The AMA supports this important patient protection because it puts the full power of the free market to work to protect consumers.

We applaud your inclusion of a comprehensive disclosure provision that allows consumers to make educated decisions as they comparison shop for health care coverage. The AMA also notes with great appreciation the many improvements that the draft bill makes over last year's Patient Protection Act.

The draft bill expands consumer protections with a perfected "emergency services" provision. By eliminating the cost differential between network and out-of-network emergency rooms, the draft bill offers expanded protection for patients who are at their most vulnerable moments.

We support the strides the draft bill takes in protecting consumers with a comprehensive ban on gag practices. This is an important consumer protection that the AMA has been seeking for more than six years.

We commend the improvements incorporated in the "appeals process" provisions of the draft bill. The bill represents a major step toward guaranteeing consumers the right to a truly independent, binding and fair review of health care decisions made by their HMO.

The April 22nd draft copy of the bill makes a strong beginning for the Commerce Committee and the 106th Congress on the issue of patient protection and reaffirms the leadership role that you have assumed in the process. While you have raised some concerns about the process, the AMA stands ready to assist in completion of this legislative task. The AMA wishes to thank you for your efforts and work with you and the minority to pass a comprehensive, bipartisan patient protection bill this year. We look forward to working with you toward this goal.

Respectfully,

E. RATCLIFFE ANDERSON, JR., MD.

Mr. Speaker, I sincerely hope that the chairmen of the committees of jurisdiction will not substantively change this draft and that they will keep it clean. It is also important that we move expeditiously on this issue. A strong patient protection bill should be debated under a fair rule on the floor by July 4.

On the floor by July 4.

Mr. Speaker, on the floor by July 4.

I look forward to working with you and with all of my colleagues to see real HMO reform signed into law this Congress.

SETTING RECORD STRAIGHT ON GAMING

The SPEAKER pro tempore (Mr. SAXTON). Under a previous order of the House, the gentlewoman from Nevada (Ms. BERKLEY) is recognized for 5 minutes.

Ms. BERKLEY. Mr. Speaker, I am dismayed about the news articles this week erroneously reporting on the gaming industry. For the benefit of my colleagues, I want to set the record straight. I offer my comments on behalf of the more than 700,000 Americans who are employed by legal and well-regulated gaming.

One recent article alleged that the gaming industry has caused major problems in our society and that it exploits the public. Another article includes the allegation that the only people who go to casinos are elderly Social Security recipients. These unfounded and outrageous allegations are a product of what objective researchers call the circle of disinformation about the gaming industry, disinformation spawned by a clique of antigaming zealots.

Unfortunately, this disinformation finds its way into the press, misleading the public and hurting the reputation of each of the 700,000 Americans employed by the industry.

Gaming must be the most studied industry in the United States, and study after study shows that the industry's customers come from all age groups, all geographic areas and from all walks of life. They choose legal gaming as a part of their leisure activities. And study after study shows that, by a large margin, Americans firmly believe that people should be allowed to par-

ticipate in gaming if they so choose to do so.

Academic studies also show that legal gaming does not cause society's problems. To the contrary, the research on the benefits of the industry to the communities are lengthy and convincing. Tens of thousands of gaming employees are in good jobs rather than being on welfare and on food stamps. Two-thirds of the gaming employees report they have better health care because of their jobs in gaming. More than 40 percent say they have better access to day care as a result of employment in the gaming industry.

The industry has a payroll approaching \$9 billion, generating tremendous community economic benefits. Gaming employees buy houses and cars and appliances. In many areas, they have ignited economic booms. For example, my hometown of Las Vegas now ranks in the top three best cities to start up a business because of favorable taxes, a lower crime rate, job growth and recreational facilities and civic pride, all stimulated by a robust gaming economy.

I encourage my colleagues to look closely at the well-documented facts about the gaming industry, rather than being influenced by the distortions that come from a circle of disinformation. I can use myself as an example, having been raised in Las Vegas. My family moved there 38 years ago. My dad was able to get a job and, because of the robust economy that the gaming industry provided Las Vegas, he managed to put a roof over our head, food on the table, clothes on our back and two daughters through college and law school. The reason for that was a robust economy fueled by the gaming industry. I ask my colleagues to look to me as an example, look to my family, look to my parents, and look to my children as cited as examples of what good community gaming can foster.

INTRODUCTION OF COMPREHENSIVE RETIREMENT SECURITY AND PENSION REFORM ACT OF 1999

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. PORTMAN) is recognized for 5 minutes.

Mr. PORTMAN. Mr. Speaker, I rise this evening to discuss an issue of great importance to so many Americans, and that is financial security in retirement. It is an important issue that has made the headlines a lot lately because of the retirement squeeze that our country faces.

We have more and more people who are going to be retiring, the baby boom generation, 76 million Americans, including myself, beginning to retire in 10 short years. We have people living much longer in this country, which is a